State of New Hampshire
Department of Health and Human Services

REQUEST FOR PROPOSALS (RFP) #16-DHHS-DPHS-RPHN-DERRY-04

FOR

Regional Public Health Network Services

for the Greater Derry Region

DATE: August 12, 2015

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1. INTRODUCTION

1.1. Purpose and Overview

This Request for Proposals is published to solicit proposals for the continued development of a range of regional public health network services and substance misuse continuum of care activities within the Greater Derry Public Health Network Region. Building upon work that has already occurred since State Fiscal Year 2014, under the leadership of the present Contractor, the Town of Derry,[1] the successful Bidder will provide services and build regional capacity in three broad areas:

- Public Health Advisory Council (PHAC);
- Public health emergency preparedness; and
- Substance misuse continuum of care.

The overarching goal of Regional Public Health Network Services is to:

- Improve the overall capacity of regional public health partners; and
- Develop a strong, regionally-based infrastructure to convene, coordinate, and facilitate an improved, systems-based approach to addressing public health issues and substance misuse to reduce costs, improve health outcomes, and reduce health disparities.

The successful Bidder will:

- Develop a Regional Public Health Advisory Council comprised of leaders from key community sectors to serve in an advisory role;
- Deliver appropriate and effective substance misuse prevention and related health promotion services through implementation of the three-year regional strategic plan;
- Plan and provide support for the development of regional capacity for a comprehensive, accessible continuum of care for substance misuse that supports the state plan recommendations, best practices and DHHS priorities;
- Plan, train for, and respond to, public health emergencies based on the US Centers for Disease Control and Prevention's (CDC) "Public Health Preparedness Capabilities: National Standards for State and Local Planning" (15 Preparedness Capabilities Standards[2]; and
- Expand delivery of the Ten Essential Public Health Services (Appendix F), to improve population health and community resilience.

[1] The Town of Derry has opted not to continue its role as the RPHN Contractor for the Greater Derry region. Its agreement with the Department for these services will end when the contract resultant from this RFP becomes effective.
[2] For more information, visit: http://www.cdc.gov/phpr/capabilities/

1.2. Definitions

Public Health Advisory Council (PHAC): a committee comprised of leaders in policy and decision-making roles, including elected and appointed public officials, leaders of non-governmental organizations and other community-based organizations that serve in an advisory role to the RPHN community stakeholders.

Public health emergency preparedness (PHEP): the ability of a state, regional, or local public health system to prevent, protect against, quickly respond to, and recover from public health emergencies, particularly those in which scale, timing, or unpredictability threatens to overwhelm routine capabilities. Activities focus on protecting and improving the overall health of communities.

Substance misuse disorders continuum of care (CC): evidence-based substance misuse prevention, early identification and intervention, treatment and recovery support programs, practices, policies and approaches within the state that refer to a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. Primary prevention includes interventions occurring prior to the initial onset of a substance use disorder through reduction or control of causative factors to substance abuse, including the reduction of risk factors contributing to substance use.

1.3. Request for Proposal Terminology

ACPIE: Assessment, capacity, planning, implementation and evaluation
ACS: Alternate Care Sites
AI: Appreciative Inquiry
Bidder: Organization submitting a proposal in response to the RFP
BDAS: Bureau of Drug and Alcohol Services
CDC: Centers for Disease Control and Prevention
CBPR: Community Based Participatory Research
CC: Continuum of Care
DHHS: Department of Health and Human Services
DCBCS: Division of Community Based Care Services
DPHS: Division of Public Health Services
EBPPP: Evidence-based programming, practices and policies
ESU: Emergency Services Unit
G&C: Governor and Executive Council
Greater Derry PHN Region: Communities of Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Salem, Sandown, and Windham (Appendix G).
HAN: Health Alert Network
HPP: Hospital Preparedness Program
HSEEP: Homeland Security Exercise and Evaluation Program
IRMS: Inventory Resources Management System
MCM ORR: Medical Counter Measures Operational Readiness Review
NEHC: Neighborhood Emergency Help Centers
PHAC: Public Health Advisory Council
POD: Points of Dispensing
PWITS: Prevention Web Information Technology System
RFP: Request for Proposal
RPHN: Regional Public Health Network

RPHN Regions: Map of 13 RPHN regions (Appendix H)
RPHEA: Regional Public Health Emergency Annex
SAMHSA: Substance Abuse and Mental Health Services Administration
SPF: Strategic Prevention Framework
SMART: Specific, Measureable, Achievable, Realistic, and Time-bound
SME: Subject Matter Experts
SMP: Substance Misuse Prevention
SNS: Strategic National Stockpile
SFY: State Fiscal Year, a term that begins July 1 and ends June 30
Vendor: Contractor

1.4. Contract Period

The contract will be effective from the date of Governor and Executive Council approval to June 30, 2017.

The Department may offer contract extensions for up to one (1) additional year, subject to the continued availability of funds, satisfactory performance of services, and approval by the Governor and Executive Council.

2. BACKGROUND AND REQUIRED SERVICES

2.1. New Hampshire DHHS Regional Public Health Network Services

Regional Public Health Network Services exist in NH's thirteen public health regions and form the framework for how public health services are delivered. This framework is the result of multiple strategic planning and capacity-building initiatives undertaken in the last decade by the Department of Health and Human Services, through its Division of Public Health Services (DPHS) and Division of Community Based Care Services (DCBCS).

2.1.1. Public Health Regionalization and the Strategic Prevention Framework (SPF)

Two initiatives, known as Public Health Regionalization[3] and the Strategic Prevention Framework (SPF), included comprehensive reviews of the existing statewide capacity to deliver public health and substance misuse prevention services regionally. These initiatives sought to build, and then expand, regional infrastructure and the capacity to deliver a range public health services. The SPF initiative initially focused on substance misuse prevention services; it has now been expanded to include the full range of services needed to address substance use disorders across the continuum of care.

[3] For more information, visit: http://www.dhhs.nh.gov/dphs/iphnh/regionalization/publications.htm

2.1.2. Transformation Initiative

A third initiative, the "Transformation Initiative," established by the DHHS Commissioner, sought to align programs, services and contracted partners to:

- Increase the effectiveness of services being provided;
- Reduce administrative burden; and
- Reduce costs for both the Department and its partners, where feasible.

Because both the DPHS and DCBCS were funding services regionally, that are based on a public health approach to improving health, the Regional SPF Network and Public Health Network programs were identified as being amenable to alignment.

2.1.3. Collective Action – Collective Impact

The Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment (hereinafter referred to as "the Commission") was established by the NH Legislature in 2000, with its membership and duties articulated in RSA 12-J:4. The development and revision, as necessary, of a statewide strategic plan for effective prevention of alcohol and drug abuse is included in the Commission's duties. The Commission issued a five-year strategic plan: "Collective Action – Collective Impact: New Hampshire's strategy to prevent and reduce alcohol and other drug misuse and promote recovery" in January 2013.[4]

2.1.4. NH State Health Improvement Plan (SHIP)

In November, 2013 the DPHS published the New Hampshire State Health Improvement Plan 2013-2020, "Charting a Course to Improve the Health of New Hampshire[5]". With input from partners from diverse sectors, agencies and organizations that address population health, and state public health system partners, 10 priority areas were identified for improvement with measurable objectives and targets for health outcomes, areas for needed attention in public health capacity, and recommendations for evidence-based interventions and actions. Reaching these targets requires a statewide initiative, and success is possible only through strategic and coordinated state, regional, and local efforts.

The New Hampshire State Health Improvement Plan (SHIP) priorities and objectives are intended to provide support, guidance, and focus for public health activities throughout the state. The NH SHIP is the state's public health road map, providing evidence-based strategies to guide the direction of many of our actions.

[4] For more information, visit: http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf
[5] For more information, visit: http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf

2.1.5. Current Status of Greater Derry Regional Initiatives

A three-year strategic plan for substance misuse prevention is being developed by the present Contractor for the Greater Derry region and will be submitted to the Department by September 30, 2015. The current Contractor also has two "mini-networks" operating: one is focused on public health emergency preparedness and another on substance misuse prevention. These "mini-networks" have set goals and priorities for the region, and have integrated the assets of their community sectors (partners) into their respective plans and programs. However, to date, there has been no significant development of a Public Health Advisory Council.

2.2. Services Funded

The services funded under this RFP will continue to implement the recommendations and priorities established through the substance misuse prevention strategic planning and public health emergency preparedness plan, and other capacity building initiatives as described above.

3. STATEMENT OF WORK

The Bidder must address every section of Section 3 Statement of Work, in the Bidder's Proposal, even though certain sections may not be scored, and must provide written answers to the questions contained herein.

3.1. Covered Populations

The Contractor shall serve as the host entity for the Greater Derry Regional Public Health Network and serve the communities covered by this region.

3.2. Required Services

3.2.1. General Services

3.2.1.1. The Contractor shall provide regional public health network services and substance misuse continuum of care activities utilizing a systems-based approach to addressing public health issues and substance misuse, with the goal of reducing costs, improving health outcomes, and reducing health disparities.

a. Contingent upon additional state or federal funding and pursuant to a mutually agreed upon contract amendment, the Contractor may be asked to provide additional services appropriate to the Greater Derry public health region and consistent with the initiatives described herein.

3.2.1.2. The Contractor shall provide or facilitate locating appropriate professional office space, meeting space, and access to office equipment to conduct RPHN business.

3.2.1.3. The Contractor shall ensure proper and regular supervision to contractually required staff in the delivery of contractual services.

3.2.2. Strategic 2015 Regional Plan for Prevention

The Contractor shall revise and implement the 2015 Regional Strategic Plan for Prevention, for the applicable region, to address substance misuse prevention and related health promotion.

3.2.3. Public Health Emergency Response Capabilities

In accordance with national standards contained in the CDC's Public Health Preparedness Capabilities: National Standards for State and Local Planning[6], the Contractor shall develop regional public health emergency response capabilities and plans based on state guidance and priorities.

3.2.4. Regional Public Health Advisory Council

3.2.4.1. The Contractor shall develop and support a regional Public Health Advisory Council (PHAC). The PHAC shall, at minimum, provide an advisory role to the Contractor and, where applicable, its subcontractors, to assure the delivery of the services funded through this contract.

The functions of the PHAC shall include:

a. Collaborating with partners to establish annual priorities to strengthen the RPHN's capabilities within the region to deliver public health services, including public health emergency response and substance misuse through the continuum of care;
b. Collaborating with the RPHN's regional partners to collect, analyze and disseminate data about the health of the region;
c. Monitoring and disseminating data products and reports to public health system partners in the region in order to inform partners about the health status of the region, and to disseminate other reports (ex. Weekly Early Event Detection Report) issued by DHHS as appropriate;
d. Educating partners on the NH WISDOM data repository, in order to build capacity to utilize this system to generate and analyze regional data;
e. Participating in local community health assessments convened by other agencies;
f. Designating representatives of the PHAC to other local or regional initiatives that are providing public health services, including public health emergencies and substance misuse through the continuum of care;
g. Developing and publishing a Community Health Improvement Plan (CHIP), by June 30, 2016, that aligns with five topic areas from the SHIP. Substance use disorders and public health emergency preparedness shall be two of the five topic areas included in the CHIP. PHAC members shall identify the other three topic areas and develop a shared agenda to implement programs, policies, and other strategies to improve the health of the people of the Greater Derry public health region. The PHAC shall:
    i. Disseminate the CHIP to regional partners and seek opportunities to educate the community about CHIP priorities, strategies, and activities;
    ii. Begin implementing the CHIP priorities in the State Fiscal Year beginning July 1, 2016;
    iii. Provide leadership to implement the priorities and strategies included in the CHIP;
    iv. Implement specific activities for:
        1. at least one (1) CHIP priority; and

[6] For more information, visit: National Standards for State and Local Planning at: http://www.cdc.gov/phpr/capabilities/

2. the following two priorities: public health emergency preparedness and substance misuse prevention / health promotion and intervention; and treatment and recovery through the substance use prevention disorders continuum of care.

v. Monitor progress of CHIP implementation and provide an annual report to regional partners and DHHS describing programs and activities implemented that address CHIP priorities.

h. Maintaining a set of operating guidelines/principles or by-laws related to the PHAC that includes:
   i. Organizational structure;
   ii. Membership;
   iii. Leadership roles and structure;
   iv. Committee roles and responsibilities;
   v. Decision-making process;
   vi. Subcommittees or workgroups;
   vii. Documentation and record-keeping; and
   viii. Process for reviewing and revising the policies and procedures.

i. Assist in the implementation of the biennial PARTNER survey of the PHAC membership at: http://www.partnertool.net/

j. Implement the PARTNER survey in the second half of SFY 2016.

k. Host at least one meeting to share results from the PARTNER survey with regional partners.

l. Maintain a webpage related to the PHAC.

m. Attend semi-annual meetings of PHAC leaders convened by the DHHS. Attendees should include a representative of the Contractor and at least one PHAC member.

n. The chair of the PHAC, or his or her designee, should be present at site visits conducted by the NH DPHS and BDAS and, to the extent possible, be available for other meetings as requested.

3.2.4.2. The Contractor shall ensure the PHAC is comprised of representatives from the community sectors identified in Table 1, Community Sectors. These sectors were developed by the US Department of Health and Human Services, Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration. While differently described, the two lists encompass essentially the same community sectors.

Table 1: Community Sectors

CDC: Public Health Preparedness	**SAMHSA:** Substance Misuse Prevention Continuum of Care
Emergency Management	Local Government: Safety and Enforcement
Health Care: Mental / Behavioral Health	Health and Medical
Cultural and Faith-based Organizations, Housing and Sheltering, Senior Services, Social Services	Community and Family Support
Business and Media	Business
Education and Child Care	Education
Community Leadership: Leaders with policy and decision-making roles, including elected and appointed public officials, leaders of non-governmental organizations and other community-based organizations. This sector includes leaders from all of the other sectors listed herein.	

3.2.4.3. The Contractor shall recruit and orient PHAC members. To achieve a broad-based advisory council comprised of senior leaders from across sectors and communities, the Contractor shall, at minimum, invite the following entities within the Contractor's designated RPHN to participate in the PHAC.

a. Each municipal and county government;
b. Each community hospital;
c. Each School Administrative Unit (SAU);
d. Each DPHS-designated community health center;
e. Each NH Department of Health and Human Services (DHHS)-designated community mental health center;
f. The Contractor;
g. Representative from each of the following community sectors shall also be invited to participate: business, cultural and faith-based organizations, social services, housing and sheltering, media, and senior services; and
h. Representatives from other sectors or individual entities, as determined by the PHAC, once it is initially formed.

It is expected that the larger PHAC will be supported by committees/workgroups comprised of professionals with more specific topical and/or function-based expertise.

3.2.4.4. The Contractor shall ensure the PHAC includes an executive or steering committee. The Contractor shall strive to include representation from the following sectors on the committee:

a. Municipal and county government (1);
b. Community hospitals (1);
c. School Administrative Unit (1);
d. DPHS-designated community health center (1);
e. DHHS-designated community mental health center (1);
f. The Contractor (1);
g. Other business, cultural and faith-based organizations, social services, housing and sheltering, media, and senior services; and
h. Representatives from other sectors or individual entities, as determined by the PHAC, once it is initially formed.

Q1. Describe how the Bidder's mission, vision and services relate to serving as a lead public health entity for the Greater Derry Public Health Region.

Q2. Describe the Bidder's experience in convening and facilitating a broad-based and diverse advisory council, or another similar body, that sets high-level goals and priorities for a collaborative effort among a number of entities. When possible, provide examples of specific outcomes that resulted.

Q3. Describe the Bidder's strategy to identify, recruit and train members for the Public Health Advisory Council as described in 3.2.4.3 and 3.2.4.4.

Q4. Describe how the Bidder will work with members to utilize health data to inform priorities; develop and implement strategic plans to improve population health; and monitor outcomes and adjust plans and strategies as needed.

3.2.5. Substance Misuse Prevention (SMP) and Related Health Promotion

3.2.5.1. The Contractor shall develop and support a regional Substance Misuse Prevention and Related Health Promotion committee which will serve as the content experts for Substance Misuse Prevention and Related Health Promotion and associated consequences. The committee shall:

a. Be under the guidance of the PHAC and inform it accordingly.
b. Consist of the six sectors listed in subsection 3.2.4.2, (Table 1, second column), Drug Free Coalitions, Student Assistance Counselors and other grassroots coalitions' representation of the region with a shared focus on substance misuse prevention, the associated consequences and health promotion.
c. Inform and guide regional efforts to ensure priorities and programs are not duplicative but rather build local capacity that is data-driven, evidence-informed, and culturally appropriate to achieve positive outcomes.
d. Review, utilize and/or revise the most recent substance misuse prevention three-year regional strategic plan and implement it.
    i. The Committee shall develop a one-year work plan by January 31, 2016 that aligns with the three-year strategic plan.
    ii. The Contractor shall ensure the regional strategic plan has been endorsed by the Committee, approved by the PHAC, and that the PHAC has issued a letter of approval in support of the plan prior to submission to BDAS.
    iii. The Contractor shall ensure the three-year plan is approved by BDAS prior to implementation.

3.2.5.2. The Contractor shall provide at least one (1) Substance Misuse Prevention Coordinator who shall:

a. Ensure the Substance Misuse Prevention and Related Health Promotion committee provides unbiased input into regional activities and development, and guidance in the implementation of the strategic plan.
b. Ensure that a portion of the Committee or a Committee member serves as the liaison to the PHAC.
c. Attend, assist and participate with the Continuum of Care facilitator and the Continuum of Care work group in the regions' capacity development in continuum of care services.
d. Attend all State required trainings, workshops, bi-monthly meetings and participate in ongoing quality improvement activities as required. Fulfillment of this requirement shall be demonstrated by attendance in and participation with the NH Center for Excellence's technical assistance events and learning collaborative(s).

3.2.5.3. The Contractor shall maintain effective training and on-going communication within the RPHN, the Substance Misuse Prevention and Related Health Promotion committee, PHAC, broader membership and all subcommittees. The Contractor shall promote the region's substance misuse prevention strategic plan's goals, objectives, activities and outcomes through media and other community information channels, and through other prevention entities as appropriate.

3.2.5.4. The Contractor shall assist DHHS in meeting the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS) through data collection, evaluation and process measures via the PWITS online data system. These regulatory requirements are described and posted on the BDAS website[7].

3.2.5.5. The Contractor shall cooperate with and coordinate all required BDAS and DPHS evaluation efforts conducted by the NH Center for Excellence (e.g. PARTNER Survey, SMP stakeholder survey and all other surveys as directed by BDAS).

3.2.5.6. The Contractor shall respond to BDAS and DPHS emails and inquiries within 3 to 5 business days or as otherwise time stated.

3.2.5.7. The Contractor shall cooperate with all BDAS site visits as required; at minimum one annually.

3.2.5.8. The Contractor shall work with BDAS and the Bureau of Liquor Enforcement to institute Comprehensive Synar Plan activities (merchant and community education efforts, youth involvement, policy and advocacy efforts, and other activities).[8]

3.2.5.9. The Contractor shall coordinate with its RPHN contract administrator in the development and the ongoing maintenance of a Substance Misuse Prevention and Health Promotion website. The website must, at minimum, contain links to www.drugfreenh.org and Bureau of Drug and Alcohol Services.

Q5. Describe the Bidder's leadership and experience with activities related to substance misuse prevention.

Q6. Describe the Bidder's experience as part of an interagency collaboration related to substance misuse prevention.

Q7. Describe the Bidder's strategy to identify, recruit and train other regional stakeholders in substance misuse prevention.

Q8. Describe how the Bidder will build upon current substance misuse prevention work and activities within the Greater Derry Region.

3.2.6. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

3.2.6.1. The Contractor shall utilize a comprehensive approach to addressing substance misuse through the continued development of a Regional Continuum of Care.

a. The Contractor shall continue to build upon the prior work and partnerships within the region utilizing the Continuum of Care statement/vision endorsed by regional partners/stakeholders.[9]

[7] For more information, visit: http://www.dhhs.nh.gov/dcbcs/bdas/documents/bg-px-noms.pdf
[8] For more information, visit: http://www.samhsa.gov/synar
[9] For more information, visit: http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm

3.2.6.2. The PHAC will provide support for the development of regional capacity for a comprehensive, accessible continuum of care for substance misuse by:

a. Ensuring the continuum of care:
   i. Supports state plan recommendations, best practice and DHHS priorities;
   ii. Includes a comprehensive service array, including development of needed capacity for environmental strategies, prevention, early identification and intervention, treatment and recovery support services
   iii. Promotes the utilization of a Resiliency and Recovery-Oriented System of Care (RROSC) construct in an effort to minimize the prevalence and consequence of substance misuse in each region.[10]
b. Participating in ongoing education on comprehensive approaches to addressing substance misuse through the development of a regional continuum of care;

3.2.6.3. The Contractor shall provide one (1) dedicated full-time Continuum of Care (CC) Facilitator. The CC Facilitator shall:

a. Work with the RPHN and communities to ensure that all necessary partners for the development of a comprehensive continuum of care, as described in subsection 3.2.6, align with the regional CHIP. These partners should include substance use Prevention, Intervention, Treatment, and Recovery providers, healthcare and behavioral health providers, and other interested or affected parties. The CC Facilitator shall work with BDAS and its technical assistance resources to ensure that all partners have access to information, training and/or technical assistance necessary for them to understand and fully participate in continuum of care development discussions and planning.
b. Be trained in the evidence-based Strategic Planning Model[11], RROSC, Resiliency and Recovery-Oriented System of Care tenants, and NH Comprehensive Systems of Care.
c. Attend and participate in the Regional PHAC meetings and planning.
d. Use the Strategic Planning Model to assess the availability of services within the continuum of care: prevention, intervention, treatment and recovery support services, including the regions' current assets and capacity for regional level services.
e. Assess substance misuse services within the Greater Derry public health network region.
f. Work with partners to establish a plan, based on the above assessment, to address the gaps and build the capacity to increase substance use disorder services across the continuum.
g. Develop a mechanism to coordinate efforts between key Prevention, Intervention, Treatment and Recovery stakeholders.
h. Reconvene or recruit subject matter experts consisting of local (when possible) healthcare providers and other professionals within the continuum to form the CC workgroup to assist and coordinate efforts.

[10] RROSC is a coordinated effort that supports a person-centered approach that builds on the strengths and resiliencies of individuals, families, and communities.
[11] The Strategic Planning Model includes five steps: assessment, capacity, develop a plan, implement the plan, evaluation.

i. Develop a plan for communication and for respective roles and responsibilities of the continuum of care workgroup.
j. Work with BDAS and its technical assistance partners to address education, training and technical assistance needs.
k. Participate in all trainings, technical assistance and evaluations as directed by BDAS.
l. Recruit representatives from community health centers, community mental health centers, hospitals, primary care, and other health and social service providers to help further the integration of healthcare and behavioral health by:
    i. Promoting substance use screenings at appropriate sites and locations.
    ii. Providing information on substance misuse trainings available for healthcare and other behavioral health providers.
    iii. Communicating information about the resources available to address substance misuse issues.
m. Assist in the continuation or development of a Continuum of Care workgroup that includes local expertise in:
    i. Prevention: Work with the Substance Misuse Coordinator and prevention providers to identify assets, address areas of need and increase access to prevention services. Coordinate this work with the regional three-year strategic prevention plan.[12]
    ii. Intervention/Treatment: Work with intervention and treatment providers to identify assets, address areas of need, increase capacity and improve access to services, and to develop and maintain established quality standards.
    iii. Primary Healthcare/Behavioral Health: Work with primary healthcare and behavioral health providers to develop a means of integrating substance misuse, mental health and primary care services within the region, including health promotion. Work with healthcare and behavioral health providers to enhance or increase substance misuse screening, other services, and/or develop new services.

3.2.6.4. Based on the work described in 3.2.6.3. m.i. through 3.2.6.3.m.iii., the Contractor shall develop a format that tracks and makes available information on Prevention, Intervention, Treatment and Recovery resources.

Q9. Describe the Bidder's experience with each substance misuse continuum of care component: prevention, early identification and intervention, treatment and recovery (this can be direct service work done by the Bidder, referrals relationships and/or partnerships, planning committees, etc.)

Q10. Describe the Bidder's plan to educate the Public Health Advisory Council on the individual, family, community and financial impact of misuse of alcohol and drugs in your region, and the components of a continuum of care and its importance.

Q11. Describe the Bidder's strategy to provide support to the Continuum of Care Facilitator, in his or her identification and recruitment of representatives from each substance misuse continuum of care component (prevention, early identification and intervention, treatment and recovery) to join a Continuum of Care workgroup.

[12] For more information, visit: https://www.dhhs.nh.gov.bdas/prevention.htm

Q12. Describe the Bidder's strategy to provide support to the Continuum of Care Facilitator and the Continuum of Care workgroup in their completion and submittal of:

- A substance misuse services assets and gaps assessment within nine (9) months of the contract's execution.
- A plan to address gaps identified in the assessment within twelve (12) months of the contract's execution.

Q13. Describe the Bidder's experience, and provide examples of, collaborative work with primary and behavioral healthcare providers.

Q14. Describe how the Bidder will work to foster integration of substance misuse services and primary and behavioral healthcare (such as partnerships, policies and practices that support identifying and addressing substance misuse issues in primary and behavioral health care settings, and partnerships, policies and practices that support identifying and addressing primary and behavioral health issues in substance misuse service settings.)

3.2.7. Regional Public Health Emergency Preparedness

The Contractor shall provide leadership and coordination to improve the readiness of regional, county, and local partners to mount an effective response to public health emergencies and threats. This will be achieved by conducting a broad range of specific public health preparedness activities to make progress toward meeting the national standards described in the U.S. Centers for Disease Control and Prevention's (CDC) Public Health Preparedness Capabilities (March 2011). All activities shall build on current efforts and accomplishments within the region. All revisions to the regional preparedness annex and appendices, as well as exercises conducted under this agreement will prioritize the building and integration of the resource elements described in the CDC Capabilities Standards.

3.2.7.1. Regional Public Health Emergency Planning

a. In collaboration with the PHAC, the Contractor shall provide leadership to further develop, exercise and update the current Regional Public Health Emergency Annex (RPHEA) and related appendices.[13] As part of this effort, the Contractor shall, at minimum:
   i. Participate in review of the RPHEA and its related appendices and attachments as requested by the DPHS. The Contractor shall revise and update the RPHEA and its related appendices and attachments based on the findings from the review.
   ii. Participate in an annual Medical Countermeasure Operational Readiness Review (MCM ORR[14]) as required by the CDC, Division of State and Local Readiness. The Contractor shall revise and update the RPHEA,

[13] The RPHEA is intended to serve as an annex or addendum to municipal emergency operations plans to activate a regional response to large-scale public health emergencies. The annex describes critical operational functions and what entities are responsible for carrying them out. The regional annex clearly describe the policies, processes, roles, and responsibilities that municipalities and partner agencies carry out before, during, and after any public health emergency. For more information about the format and structure of emergency plans go to: https://www.fema.gov/media-library/assets/documents/25975.

[14] The MCM ORR outlines planning elements specific to managing, distributing and dispensing Strategic National Stockpile (SNS) materiel received from the CDC during a public health emergency. See Appendix J -- MCM ORR Provisional Guide, in draft form, for more information.

related appendices and attachments based on the findings from the MCM ORR.

iii. The Contractor shall develop new incident-specific appendices based on priorities identified by the DPHS. The DPHS will provide planning templates and guidance for use by the Contractor.

iv. The Contractor shall submit the RPHEA and all related appendices and attachments to the NH DPHS by June 30 of each year. Submission shall be in the form of a single hard copy and by posting all materials on E-Studio[15].

b. The Contractor shall disseminate the RPHEA and related materials to planning and response partners, including municipal officials from each municipality in the region. Dissemination may be through hard copy or electronic means.

3.2.7.2. The Contractor shall collaborate with hospitals receiving funds under the U. S. DHHS' Hospital Preparedness Program (HPP) cooperative agreement to strengthen and maintain a healthcare coalition in accordance with the Healthcare Preparedness Capabilities-National Guidance for Healthcare System Preparedness.[16]

3.2.7.3. The Contractor shall collaborate with municipal emergency management directors to integrate the assets and capabilities included in the RPHEA into municipal and regional shelter plans.

3.2.7.4. The Contractor shall review existing Memorandums of Understanding (MOUs) executed by the previous Contractor, Town of Derry, on behalf of the Greater Derry region with governmental, public health, and health care entities that describe the respective roles and responsibilities of the parties in the planning and response to a public health emergency. The Contractor shall execute new MOUs to ensure the Contractor is a party to the MOUs.

3.2.7.5. The Contractor shall implement at least one priority intervention identified in the work plan developed following the regional Hazard Vulnerability Assessment (Appendix I) conducted during SFY 13.

Q15. Describe the Bidder's experience in preparing for emergencies:

- as an individual entity;
- as part of an interagency collaboration; and
- as part of the current public health emergency preparedness initiative in the region.

Q16. Describe and provide examples of the Bidder's experience in writing detailed operational plans, procedures and policies. When possible, describe examples that included multiple entities collaborating on shared plans, procedures and policies.

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[15] EStudio is a web-based document sharing system maintained by the DPHS.

[16] Healthcare coalitions consist of a collaborative network of healthcare organizations and their respective public and private sector response partners. Healthcare coalitions serve as a multi-agency coordinating group that assists local Emergency Management and Emergency Support Function (ESF) #8 with preparedness, response, recovery and mitigation activities related to healthcare organization disaster operations. For more information visit: http://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf

Q17. Describe the Bidder's strategy to identify, recruit and train volunteers to help staff: Points of Dispensing, Alternate Care Sites, and Neighborhood Emergency Help Centers during emergencies. When possible, describe the Bidder's experience in managing other groups of volunteers.

Q18. Describe how the Bidder will provide leadership during the response phase of a public health emergency by activating the Regional Public Health Emergency Annex and coordinating partnering response entities.

3.2.8. Regional Public Health Emergency Response Readiness

3.2.8.1. The Contractor shall engage with community organizations to foster connections that assure public health, medical and behavioral health services in the region before, during and after an incident.

3.2.8.2. Through the PHAC, the Contractor shall continue to collaborate with community organizations to improve the capacity within the region to deliver the Ten Essential Public Health Services (Appendix F)

3.2.8.3. The Contractor shall coordinate the procurement, rotation and storage of supplies necessary for the initial activation of Alternate Care Sites (ACS), Neighborhood Emergency Help Centers (NEHCs) and Points of Dispensing (POD) and support public health, health care and behavioral health services in emergency shelters located within the region.

3.2.8.4. In coordination with the Town of Derry and NH DHHS, the Contractor shall receive transferred oversight and management of supplies and 5 storage trailers from the current Contractor, to ensure the ability to deploy these assets during a response. All transfers of ownership of the storage trailers must have the prior approval of NH DHHS. The Contractor shall update and execute MOUs with partnering agencies to store, inventory, and rotate these supplies.

3.2.8.5. The Contractor shall enter and maintain data about the region's response supplies in the Inventory Resources Management System (IRMS), administered by the NH DHHS Emergency Services Unit (ESU), in order to track and manage medical and administrative supplies owned by the Contractor.

3.2.8.6. The Contractor shall conduct an inventory of regional supplies at least annually and after every deployment of these supplies. The Contractor will be granted administrative access rights to IRMS in order to complete this activity.

3.2.8.7. The Contractor shall disseminate information about, and link appropriate public health and health care professionals with NHResponds[17] to allow for the timely activation of volunteers during emergency events.

[17] For more information about NHResponds, visit: (https://www.nhresponds.org/nhhome.aspx).

3.2.8.8. The Contractor shall disseminate information about the NH Health Alert Network (HAN)[18] and refer appropriate individuals interested in enrolling in the HAN to the DPHS HAN Coordinator. The Contractor shall receive, and act on as necessary, HAN notices issued by the DPHS to ensure local partners remain aware of recommendations and guidance issued by the DPHS.

3.2.8.9. To maximize the Department's ability to quickly respond to a public health emergency, the Contractor shall assess its current capacity to timely receive and expend additional federal and state funds that may become available on an urgent basis to respond to a public health emergency. The assessment shall be completed within ninety (90) days of contract approval and its results shall be provided to the Department for review. The Contractor shall develop an improvement plan within 180 days of contract approval if requested by the Department. The plan shall be subject to the Department's approval.

3.2.8.10. Sponsor and organize the logistics for at least two trainings/in-services for regional partners. Collaborate with the DHHS, DPHS, the NH Institute of Public Health Practice, the Community Health Institute in Bow, NH, the Preparedness Emergency Response Learning Center at Harvard University and other training providers to implement these training programs. Enter information about training programs and individuals trained into a learning management system administered by NH DPHS to track training programs.

3.2.8.11. In coordination with the DHHS, assume responsibility for the Greater Derry Medical Reserve Corps (MRC) according to guidance from the federal MRC program[19] and the DHHS. This unit may be continued as a stand-alone unit or integrated into an adjoining public health region's MRC.

3.2.8.12. Conduct outreach to at least two health care entities to recruit health care workers with the skills, licensure and credentialing needed to fill positions described in the RPHEA, and related appendices.

3.2.9. Public Health Emergency Drills and Exercises

3.2.9.1. Plan and execute drills and exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP).[20]

3.2.9.2. Maintain a three-year Training and Exercise Plan (TEP) that, at a minimum, includes all drills and exercises as required under the SNS program.

3.2.9.3. Based on the mutual agreement of all parties and as funding allows, participate in drills and exercises conducted by the NH DPHS, NH DHHS ESU, and NH Homeland Security and Emergency Management (HSEM). As funding allows, this includes all drills and exercises conducted by NH DHHS for a full-scale exercise regarding medical countermeasures distribution and/or dispensing.

[18] The HAN is an alerting and notification system administered by the NH DPHS.
[19] For more information, visit: https://www.medicalreservecorps.gov/HomePage
[20] For more information, visit: http://www.fema.gov/media-library-data/20130726-1914-25045-8890/hseep_apr13_.pdf

3.2.9.4. Collaborate with local emergency management directors, hospitals, and public health system partners to seek funding to support other workshops, drills and exercises that evaluate the CDC Capabilities Standards based on priorities established by regional partners.

3.2.9.5. To the extent possible, participate in workshops, drills and exercises as requested by local emergency management directors or other public health partners.

3.3. Performance Measures

The Contractor shall ensure that the following performance measures are met:

3.3.1. Regional Public Health Advisory Council

3.3.1.1. Representation of at least 70% of the 11 community sectors identified in the CDC Public Health Preparedness Capabilities: National Standards for State and Local Planning (15 Preparedness Capabilities Standards[21]), that participate in the Regional Public Health Advisory Council.

3.3.1.2. Representation of 65% of the 6 community sectors identified in the Governor's Commission plan that participate in the Regional Public Health Advisory Council.

3.3.1.3. Documented organizational structure for the Regional Public Health Advisory Council (e.g. vision or mission statements, by-laws or guiding principles, organizational charts, MOUs, minutes, etc.).

3.3.1.4. Establish and increase over time regional connectivity among stakeholders and improved trust among partners via the biennial PARTNER Survey.

3.3.2. Substance Misuse Prevention (SMP) and Related Health Promotion

3.3.2.1. Recommitment or revision of the 3 year substance misuse prevention plan and as endorsed by Regional Public Health Advisory Council and approved by BDAS due January 1, 2016.

3.3.2.2. Completed and approved annual work plan reflective of current strategic plan due February 1, 2016.

3.3.2.3. Completed monthly PWITS data entries due by the 20th business days of the following month (e.g. September data due by October 30).

3.3.2.4. Data must align with the three-year strategic plan for substance misuse prevention and health promotion and adhere to the PWITS Policy Guidance document.

3.3.2.5. Host at minimum 4 SMP expert team meetings annually.

3.3.2.6. Meet all Federal regulatory reporting requirements of the Substance Abuse Prevention and Treatment Block Grant.

3.3.2.7. Participates and coordinates evaluation surveys: SMP stakeholder survey and other surveys as required.

[21] For more information, visit: http://www.cdc.gov/phpr/capabilities/

3.3.2.8. Participates and coordinates attendees and prepares for BDAS or DPHS site visits. At request of the State, the Contractor may be asked to convene the Substance Misuse Prevention Coordinator, its contract administrator, financial agent, expert team chair and others as requested.

3.3.2.9. Attendance at SMP bi-monthly meetings jointly convened by BDAS and the NH Charitable Foundation.

3.3.2.10. Maintain an SMP website with links to drugfreenh.org and BDAS.

3.3.2.11. Provides additional information to BDAS when requested.

3.3.3. Regional Continuum of Care (CC) for Substance Misuse

3.3.3.1. One full time dedicated Continuum of Care (CC) facilitator hired and completed all required trainings.

3.3.3.2. CC Facilitator establishes and convenes the Continuum of Care (CC) workgroup from across the continuum of care that includes participants from prevention, intervention, treatment and recovery, healthcare and primary care providers and behavioral health.

3.3.3.3. Submission of meeting minutes including detailed conversations and action items, and CC workgroup attendance.

3.3.3.4. Submission of an assessment of regional continuum of care assets, gaps and barriers to service within nine (9) months of the approved contract to include:

a. Identification of gaps in CC substance misuse components and services (prevention, early intervention, treatment and recovery support services) that need to be developed or enhanced.
b. Identification of barriers to cooperation between CC components and services.
c. Identification of barriers to community/client access to component services.

3.3.3.5. Submission of a plan within one (1) year of the approved contract that identifies actions to address issues in the assessment of regional continuum of care assets, gaps and barriers to services, work plan outlining the activities to be implemented to resolve any barriers and increase capacity of services within the region.

3.3.4. Regional Public Health Preparedness

3.3.4.1. Score assigned to the region's capacity to dispense medications to the population based on the CDC MCM ORR.

3.3.4.2. Number of outreach events with entities that employ health care personnel.

3.3.4.3. Submission of the RPHEA annually.

3.4. Staffing

The selected Bidder must provide staffing to meet the requirements of this RFP, which will be incorporated into the resultant contract.

3.4.1. General Staffing Requirements

3.4.1.1. The Contractor must provide sufficient staff to perform all specified tasks specified in the contract and maintain a level of staffing necessary to perform all functions, requirements, roles, and duties in a timely manner.

3.4.1.2. The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and must verify and document that it has met this requirement. This includes keeping up-to-date records and documentation of all individuals requiring licenses and/or certifications. Such records must be available for DHHS inspection upon request.

3.4.2. Mandatory Minimum Staffing Requirements

3.4.2.1. The Contractor shall maintain and/or hire a full-time-equivalent Substance Misuse Prevention Coordinator(s) to manage the Substance Misuse project activities, including those described in subsections 3.2.6 and 3.2.7, with one person serving as the primary point of contact and management of the applicable scope of work. The Substance Misuse Prevention Coordinator(s) must be a Certified Prevention Specialist (CPS), or pending certification within one year of the contract's start and a graduate from a four year university.

3.4.2.2. One (1) dedicated full-time Continuum of Care (CC) Facilitator. The minimum qualifications for this position are:

a. Master's degree in Public Health with focus on systems development, or
b. Master's degree in Social Work with focus or experience in macro social work, or
c. Master's degree in Community Development/Organizing, or
d. Bachelor's degree any of the above with 2-3 years' experience in public health systems development, macro social work, or community development/organizing.

Q19. Provide the Bidder's proposed staffing plan and organizational chart. Include resumes and qualifications of filled positions, and job descriptions and qualifications needed for vacant positions.

3.5. Delegation and Subcontractors

DHHS recognizes that Bidders may choose to use subcontractors with specific expertise to perform certain services or functions for efficiency or convenience. However, the successful bidder, as the Contractor, shall retain the responsibility and accountability for the function(s).

If Bidder uses subcontractors for this scope-of-work, this must be disclosed in the proposal submittal along with details of direct and indirect expenses to accompany details in the work plan, within the budget and the budget narrative.

Q20. Submit the Bidder's proposed plans for subcontracting any of these services, including any existing sub-contractual agreements. Signed letters of commitment from the subcontractor(s) are required.

3.5.1. Prior to Subcontracting

3.5.1.1. Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:

a. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function.
b. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate.
c. Monitor the subcontractor's performance on an ongoing basis.

3.5.2. Review and Approval of Subcontractors

3.5.2.1. The Contractor shall provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed.

3.5.2.2. If the Contractor identifies deficiencies, or areas for improvement are identified, the Contractor shall take corrective action.

3.5.2.3. DHHS shall, at its discretion, review and approve all subcontracts.

3.5.2.4. DHHS reserves the right to approve or reject any subcontractor used for this contract.

3.6. Training and Technical Assistance Requirements

The Contractor shall participate in training and technical assistance programs offered to agencies receiving funds under this agreement, in addition to the following responsibilities:

3.6.1. Regional Public Health Preparedness

3.6.1.1. Participate in bi-monthly Preparedness Coordinator technical assistance meetings.

3.6.1.2. Develop and implement a technical assistance plan for the region, in collaboration with the Community Health Institute, which is under contract with the NH DPHS to provide that technical assistance.

3.6.1.3. Complete the training standards recommended for Preparedness Coordinators.

3.6.1.4. Attend the annual Statewide Preparedness Conferences in June 2016 and 2017.

3.6.2. Medical Reserves Corps

3.6.2.1. Participate in the development of a statewide technical assistance plan for MRC units.

3.6.3. Substance Misuse Prevention and Related Health Promotion

3.6.3.1. Participate in bi-monthly SMP meetings.

3.6.3.2. Maintain Prevention Specialist Certification credentialing.

3.6.3.3. Ongoing quality improvement is required as demonstrated by attendance and participation with the Center for Excellence on or off site technical assistance and trainings.

3.7. Administration and Management – All Services

3.7.1. Work Plan

3.7.1.1. The Contractor shall monitor progress on the final work plans approved by the DHHS. There must be a separate work plan for each of the following, based on the services being funded:

a. Regional Public Health Advisory Council
b. Substance Misuse Prevention and Related Health Promotion
c. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care
d. Regional Public Health Emergency Preparedness

3.7.2. Reporting, Contract Monitoring and Performance Evaluation Activities

3.7.2.1. Site Visits: the Contractor shall participate in an annual or semi-annual site visit with DHHS, DPHS and BDAS staff. Site visits will include:

a. Reviewing the progress made toward meeting the deliverables and requirements described in the Scope of Services based on an evaluation plan that includes performance measures.
b. Assessing subcontractors. Subcontractors must attend all site visits as requested by DHHS.
c. Reviewing/conducting a financial audit in accordance with state and federal requirements.
d. Assessing the Contractor's policies and procedures to determine areas to improve the ability to expedite the acceptance and expenditure of funds during public health emergencies.
e. Assessing the Contractor's capacity to apply for state and federal reimbursement for costs incurred during declared emergencies.
f. Assessing the Contractor's capacity to accept and expend new state or federal funds during the contract period for additional public health and substance use disorders continuum of care services.

3.7.2.2. Educational Materials: the Contractor shall submit for approval all educational materials developed with contract funds, prior to printing or dissemination by other means.

3.7.2.3. Programmatic Updates: the Contractor shall provide other programmatic updates as requested by DHHS.

3.7.2.4. Public Health Advisory Council and Public Health Preparedness:

a. The Contractor shall engage the Regional Public Health Advisory Council to provide input about how the Contractor can meet its overall obligations and responsibilities under the contract's Scope of Services.

b. The Contractor shall provide the Regional Public Health Advisory Council with information about state and regional issues that:
   i. are related to public health;
   ii. are related to substance misuse prevention and related health promotion; and that
   iii. may impact the health and wellness of the public and the ability of communities to respond to and recover from emergencies.
c. The Contractor shall facilitate awareness of the Regional Public Health Advisory Council and about the Contractor's performance under the contract, by allowing a representative from the Regional Public Health Council to participate in site visits and other meetings with the NH DHHS related to the activities being conducted under the contract.
d. The Contractor shall submit quarterly progress reports based on performance using reporting tools developed by the DPHS.
e. As requested by the DPHS, the Contractor shall complete membership assessments to meet CDC and Assistant Secretary for Preparedness and Response (ASPR) requirements.

3.7.2.5. Substance Misuse Prevention (SMP) and Related Health Promotion:

a. The Contractor shall complete monthly data entry in the BDAS PWITS system that aligns and supports the regional substance misuse prevention and related health promotion plan.
b. The Contractor shall submit the following information and reports to DHHS:
   i. Updated or revised strategic plans for approval prior to implementation.
   ii. Annual reports, which shall be submitted to BDAS and due by June 25, 2016 and 2017. A template for the report and guidance will be provided to the Contractor by the Center for Excellence.
c. The Contractor shall cooperate with and coordinate all evaluation efforts conducted by the Center for Excellence, (e.g. Stakeholder Survey, annual environmental measure, and other surveys as directed by BDAS).
d. The Contractor shall provide additional information, as required by BDAS.

3.7.2.6. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care:

a. The Contractor shall submit the following to DHHS:
   i. Quarterly reports; dates for submissions and template will be provided by BDAS.
   ii. A report on prevention, intervention, treatment and recovery services gap assessment within nine (9) months of the date of contract.
   iii. A plan to address gaps in services identified within twelve (12) months of the contract's execution.

3.8. Compliance

3.8.1. Culturally and Linguistically Appropriate Standards

The New Hampshire Department of Health and Human Services (DHHS) is committed to reducing health disparities in New Hampshire. DHHS recognizes that culture and language can have a considerable impact on how individuals access and respond to health and human services. Culturally and linguistically diverse populations experience barriers in their efforts to access services. As a result, DHHS is strongly committed to providing culturally and linguistically competent programs and services for its clients, and as a means of ensuring access to quality care for all. As part of that commitment DHHS continuously strives to improve existing programs and services, and to bring them in line with current best practices.

3.8.1.1. DHHS requires all contractors and sub-recipients to provide culturally and linguistically appropriate programs and services in compliance with all applicable federal civil rights laws, which may include: Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Rehabilitation Act of 1973. Collectively, these laws prohibit discrimination on the grounds of race, color, national origin, disability, age, sex, and religion.

3.8.1.2. There are numerous resources available to help recipients increase their ability to meet the needs of culturally, racially and linguistically diverse clients. Some of the main information sources are listed in the Bidder's Reference Guide for Completing the Culturally and Linguistically Appropriate Services section of the RFP, and, in the Vendor/RFP section of the DHHS website.

3.8.1.3. A key Title VI guidance is the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), developed by the U.S. Department of Health and Human Services in 2000. The CLAS Standards provide specific steps that organizations may take to make their services more culturally and linguistically appropriate. The enhanced CLAS standards, released in 2013, promote effective communication not only with persons with Limited English Proficiency, but also with persons who have other communication needs. The enhanced Standards provide a framework for organizations to best serve the nation's increasingly diverse communities.

3.8.1.4. Bidders are expected to consider the need for language services for individuals with Limited English Proficiency as well as other communication needs, served or likely to be encountered in the eligible service population, both in developing their budgets and in conducting their programs and activities.

3.8.1.5. Successful applicants will be:

a. Required to submit a detailed description of the language assistance services they will provide to LEP persons to ensure meaningful access to their programs and/or services, within 10 days of the date the contract is approved by Governor and Council;
b. Monitored on their Federal civil rights compliance using the Federal Civil Rights Compliance Checklist, which can be found in the Vendor/RFP section of the DHHS website.

3.8.1.6. The guidance that accompanies Title VI of the Civil Rights Act of 1964 requires recipients to take reasonable steps to ensure meaningful access to their programs and services by persons with Limited English Proficiency (LEP persons). The extent of an organization's obligation to provide LEP services is based on an individualized assessment involving the balancing of four factors:

a. The number or proportion of LEP persons served or likely to be encountered in the population that is eligible for the program or services (this includes minor children served by the program who have LEP parent(s) or guardian(s) in need of language assistance);
b. The frequency with which LEP individuals come in contact with the program, activity or service;
c. The importance or impact of the contact upon the lives of the person(s) served by the program, activity or service;
d. The resources available to the organization to provide language assistance.

3.8.1.7. **Bidders are required to complete the TWO (2) steps listed in the Appendix C to this RFP, as part of their Proposal.** Completion of these two items is required not only because the provision of language and/or communication assistance is a longstanding requirement under the Federal civil rights laws, but also because consideration of all the required factors will help inform Bidders' program design, which in turn, will allow Bidders to put forth the best possible Proposal.

For guidance on completing the two steps in Appendix C, please refer to Bidder's Reference Guide for Completing the Culturally and Linguistically Appropriate Services Addendum of the RFP, which is posted on the DHHS website. http://www.dhhs.nh.gov/business/forms.htm.

3.8.2. Substance Misuse Prevention (SMP) and Related Health Promotion

3.8.2.1. The Contractor shall ensure that the following regulatory requirements and compliance issues are adhered to:

a. All programs and practices shall utilize evidence-informed approaches for substance misuse prevention, as outlined in the NH BDAS/NHCE document, Selecting Evidence-Informed Substance Misuse Prevention Strategies: Resources for the New Hampshire Prevention System[22].
b. The Strategic Prevention Framework (SPF) five-step planning process to guide regions/communities in the data driven planning process planning, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities at http://www.samhsa.gov/spf is utilized.
c. Substance misuse prevention plans and regional efforts adhere to the Federal Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959) requirements[23].
d. Prevention approaches must target primary prevention strategies. These strategies are directed at individuals not identified to be in need of treatment.

[22] For more information, visit: http://www.dhhs.nh.gov/dcbcs/bdas/documents/evidenceinformedpx.pdf
[23] For more information, visit: http://www.samhsa.gov/sites/default/files/grants/sabg-reporting-16-17.pdf

e. Comprehensive primary prevention program shall include activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to the Center for Substance Abuse Prevention categories: Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-based Process, and Environmental.
   i. A comprehensive approach using the above categories targeting populations with different levels of risk classified by the Institute of Medicine Model: Universal, Selective, and Indicated, as outlined in regulatory requirements.[24]

All the above information is outlined in more detail under the heading Primary Prevention at http://www.samhsa.gov/grants/block-grants/sabg.

4. FINANCE

4.1. Financial Funding Sources

Funds to support this project are available from three funding sources, identified as follows:

4.1.1. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

Block Grants for Prevention and Treatment of Substance Abuse Funds to support this project are available from the Catalog of Federal Domestic Assistance (CFDA) #93.959, Federal Award Identification Number (FAIN) TI010035-15

4.1.2. US Department of Health and Human Services, Centers for Disease Control and Prevention

Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreement Funds to support this project are available from the Catalog of Federal Domestic Assistance (CFDA) #93.074, Federal Award Identification Number (FAIN) U90TP000535

Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)Funds to support this project are available from the Catalog of Federal Domestic Assistance (CFDA) #93.758, Federal Award Identification Number (FAIN) B01OT009037

[24] For more information, visit: http://www.dhhs.nh.gov/dcbcs/bdas/documents/bg-px-noms.pdf

4.2. Anticipated Available Funding

Funds are anticipated to be available as shown in Table 2 below.

Table 2

Program Area	SFY 16	SFY 17	Total
Regional Public Health Advisory Council	$ 30,000	$ 30,000	$ 60,000
Substance Use Disorders Continuum of Care	$107,680	$150,380	$258,060
Public Health Preparedness	$ 60,783	$ 85,783	$146,566
Total	$198,463	$266,163	$464,626

Estimates of available funding and time periods presented here are subject to change. Continuance of contract payments is contingent upon the availability and continued appropriations of funds. The Department may renegotiate the terms and conditions of the contract in the event applicable local, state, or federal law, regulations or policy are altered from those existing at the time of the contract in order to be in continuous compliance therewith

4.3. Appropriate Use of Funds

Funds must be used in accordance with the provisions of the CFDA numbers referenced in subsection 4.1.1 and funding amounts in 4.1.2. Funds from this contract shall not be used to supplant funding for a program already funded from another source.

4.4. Matching of Funds

This project requires a cash match; an in-kind match is not acceptable in lieu of the cash match. A cash match is real cash contributed to the project. In contrast, in-kind matches are typically defined as things that could already exist within the contractor's organization and are donated to the contracted project, such as the use of existing personnel, without being reimbursed from the contract's funds for such use.

The successful Bidder is required to provide a cash match in the amount of $20,000 to support the position(s) and or related expenses of staff responsible for substance misuse prevention and related health promotion. This match can derive from the Bidder's internal resources or from external resources.

For Bidders looking to secure the required match from one or more external parties, it is understood that Bidders may not be able to obtain a legal commitment for these funds, from such parties, in advance of contract award. However, Bidders should, at minimum, be able to demonstrate some level of commitment from a third party for these funds, should the Bidder be awarded this contract, and to obtain the party's legal commitment within 90 days of contract award to the Bidder.

Bidders should be aware that the New Hampshire Charitable Foundation has expressed interest in leveraging and enhancing the capacity of organizations under contract with the New Hampshire Department of Health and Human Services for providing community/regionally based alcohol and other drug prevention activities. It should be understood that this information does not in any way commit the New Hampshire Charitable Foundation to provide any funding for this project. Bidders are in no way limited to exclusively utilizing funding from the New Hampshire Charitable Foundation for the required match. No Bidder that utilizes this potential source of funds, over any other source of funds, for its required match will be given any preference for the award of this contract.

4.5. Financial Reporting Requirements

The Contractor shall file monthly Financial Reports to DHHS utilizing the reporting tool provided by DHHS. Expenses will be reported for reimbursement by budget line item and funding sources.

4.6. Budget

4.6.1. General Information

4.6.1.1. The Budgets (Appendix D), Program Staff List (Appendix E), and detailed Budget Narratives submitted shall represent the total program cost; the State will not provide reimbursement for any operational or other costs outside of the budget. Final Budgets and Program Staff Lists, incorporated into the resultant contract, are subject to DHHS approval.

4.6.1.2. The Budget Form shall be completed with the direct and indirect fixed costs, and shall include the allocation method for the indirect fixed costs, and match funding as identified in subsection 4.4. The Budget shall include a detailed Budget Narrative and Program Staff Lists, with line item detail for direct, indirect costs, and match (as detailed in the Budget Forms) in order to be considered.

4.6.1.3. The narratives must clearly address staff utilization for each area of required services detailed in Section 3 – Statement of Work, and clearly tie to the Program Staff List (Appendix E).

4.6.1.4. Supporting information shall be provided in sufficient detail so that the State can clearly understand the reasonableness of the cost proposal. Information shall include, but is not limited to, the basis for determining individual salaries, benefit rates, rates for supporting professional development, insurance, and indirect cost.

4.6.2. Required Budget Items

Proposals shall include the following items, one for each programmatic area and each State Fiscal Year (SFY):

4.6.2.1. Budget Form (Appendix D) - this form details the costs of the Bidder's Proposal by program area and by SFY.

4.6.2.2. Budget Narrative - (Not to exceed 3 pages per SFY).

a. Describe in detail each expense item and personnel position for which funding is requested, linking each to the services to be provided. Use the

cost categories and numbered items as described in the Budget Form to organize the budget justification narrative.

b. Ensure that the budget is appropriate in relation to the proposed activities, reasonable, clearly justified, and consistent with the intended use of funds. Proposals should provide the best value for cost/price bid.
c. Direct incremental costs should accurately reflect new costs associated with this program or service.
d. Allocation methodology for the indirect fixed costs.

4.6.2.3. A Program Staff List form (Appendix E) shall be completed for each program area and for each SFY.

Microsoft Excel versions of the Budget Form (Appendix D) and Program Staff List (Appendix E) are made available by request to the Procurement Coordinator specified in subsection 6.1

5. PROPOSAL EVALUATION

5.1. Technical Proposal – 360 Points

5.1.1. Proposal Narrative, Project Approach and Technical Response

Public Health Advisory Council (Q1-Q4)……	85 Points
Substance Misuse Prevention and Related Health Promotion (Q5-Q8)….	75 Points
Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care (Q9-Q14)……..	75 Points
Public Health Emergency Preparedness (Q15-Q18)……..	75 Points
Staffing Plan (Q19-Q20)……..	50 Points

5.2. Cost Proposal – 185 Points

Budgets……..	125 Points
Budget Narratives…….	60 Points
Total points available for this RFP.....	545 Points

6. PROPOSAL PROCESS

6.1. Contact Information – Sole Point of Contact

The sole point of contact, the Procurement Coordinator, relative to the bid or bidding process for this RFP, from the RFP issue date until the selection of a Bidder, and approval of the resulting contract by the Governor and Executive Council is:

State of New Hampshire
Department of Health and Human Services
Bobbie Aversa
Contracts & Procurement
Brown Building
129 Pleasant St.
Concord, New Hampshire 03301
Email: baversa@dhhs.state.nh.us
Fax: 603-271-8431
Phone: 603-271-9563

Other personnel are NOT authorized to discuss this RFP with Bidders before the proposal submission deadline. Contact regarding this RFP with any State personnel not listed above could result in disqualification. The State will not be held responsible for oral responses to Bidders regardless of the source.

6.2. Procurement Timetable

Table 3

Procurement Timetable

(**All times are according to Eastern Time. DHHS reserves the right to modify these dates at its sole discretion.)**

Item	Action	Date
1.	Release RFP	08/12/2015
2.	Optional Letter of Intent	08/20/2015
3.	RFP Technical and Cost Proposal Conference	09/01/2015 10:00 AM
4.	RFP Technical and Cost Questions Submission Deadline	09/01/2015 3:00 PM
5.	DHHS Response to Technical and Cost Questions Published	09/04/2015
6.	Technical and Cost Bids Submission Deadline	09/15/2015 2:00 PM
7.	Anticipated Selection of Successful Bidder(s)	09/18/2015
8.	Anticipated Contract Effective Date	11/18/2015

6.3. Letter of Intent

A Letter of Intent to submit a Proposal in response to this RFP is optional but strongly recommended. However, please submit it by the date and time identified in subsection 6.2: Procurement Timetable.

Receipt of the Letter of Intent by DHHS will be required in order to receive any correspondence regarding this RFP, any RFP amendments, in the event such are produced, or any further materials on this project, including electronic files containing tables required for response to this RFP, any addenda, corrections, schedule modifications, or notifications regarding any informational meetings for Bidders, or responses to comments or questions.

The Letter of Intent may be transmitted by e-mail to the Procurement Coordinator identified in subsection 6.1, but must be followed by delivery of a paper copy within two (2) business days to the Procurement Coordinator identified in subsection 6.1.

The potential Bidder is responsible for successful e-mail transmission. DHHS will provide confirmation of receipt of the Letter of Intent if the name and e-mail address or fax number of the person to receive such confirmation is provided by the Bidder.

The Letter of Intent must include the name, telephone number, mailing address and e-mail address of the Bidder's designated contact to which DHHS will direct RFP related correspondence.

6.4. Bidders' Questions and Answers

6.4.1. Bidders' Questions

All questions about this RFP, including but not limited to requests for clarification, additional information or any changes to the RFP must be made in writing, citing the RFP page number and part or subpart, and submitted to the Procurement Coordinator identified in subsection 6.1.

DHHS may consolidate or paraphrase questions for efficiency and clarity. Questions that are not understood will not be answered. Statements that are not questions will not receive a response.

Questions will only be accepted from those Bidders who have submitted a Letter of Intent by the deadline given in subsection 6.2, Procurement Timetable. Questions from all other parties will be disregarded. DHHS will not acknowledge receipt of questions.

The questions may be submitted by fax or e-mail; however, DHHS assumes no liability for assuring accurate and complete fax and e-mail transmissions.

Questions must be received by DHHS by the deadline given in subsection 6.2, Procurement Timetable.

6.4.2. Bidders' Conferences

6.4.2.1. Technical Proposal Conference

The Technical Proposal Conference will be held on the date specified in subsection 6.2, Procurement Timetable, in the Auditorium in the Brown Building, 129 Pleasant Street, Concord, New Hampshire. The conference will serve as an opportunity for Bidders to ask specific questions of State staff concerning the technical requirements of the RFP.

Attendance at the Technical Proposal Conference is not mandatory but is highly recommended. Contact the Procurement Coordinator specified in subsection 6.1 to register for the Technical Proposal Conference.

6.4.2.2. Cost Proposal Conference

The Cost Proposal Conference will be held on the date specified in subsection 6.2 Procurement Timetable, in the Auditorium in the Brown Building, 129 Pleasant Street, Concord, New Hampshire. The conference will serve as an opportunity for Bidders to ask specific questions of State staff concerning the cost requirements of the RFP.

Attendance at the Cost Proposal Conference is not mandatory but is highly recommended. Contact the Procurement Coordinator specified in subsection 6.1 to register for the Cost Proposal Conference.

Bidders may attend the Cost Proposal Conference via webinar. Contact the Procurement Coordinator, specified in subsection 6.1, for information about attending this webinar.

6.4.3. DHHS Answers

DHHS intends to issue responses to properly submitted questions by the deadline specified in subsection 6.2, Procurement Timetable. Oral answers given in the Bidders Conferences are non-binding. Written answers to questions asked in the Bidder Conferences will be posted on the DHHS Public website[25] and sent as an attachment in an e-mail to the contact identified in accepted Letters of Intent. This date may be subject to change at DHHS discretion.

6.5. RFP Amendment

DHHS reserves the right to amend this RFP, as it deems appropriate prior to the Proposal Submission Deadline on its own initiative or in response to issues raised through Bidder questions. In the event of an amendment to the RFP, DHHS, at its sole discretion, may extend the Proposal Submission Deadline. Bidders who submitted a Letter of Intent will receive notification of the amendment, and the amended language will be posted on the DHHS Internet site.

6.6. Proposal Submission

Proposals submitted in response to this RFP must be received no later than the time and date specified in subsection 6.2, Procurement Timetable. Proposals must be addressed for delivery to the Procurement Coordinator specified in subsection 6.1, and marked with RFP **#16-DHHS-DPHS-RPHN-DERRY-04**.

[25] Visit: http://www.dhhs.nh.gov/business/rfp/index.htm

Late submissions will not be accepted and will remain unopened. Disqualified submissions will be discarded if not re-claimed by the bidding Bidder by the time the contract is awarded. Delivery of the Proposals shall be at the Bidder's expense. The time of receipt shall be considered when a Proposal has been officially documented by DHHS, in accordance with its established policies, as having been received at the location designated above. The State accepts no responsibility for mislabeled mail. Any and all damage that may occur due to shipping shall be the Bidder's responsibility.

6.7. Compliance

Bidders must be in compliance with applicable federal and state laws, rules and regulations, and applicable policies and procedures adopted by the Department of Health and Human Services currently in effect, and as they may be adopted or amended during the contract period

6.8. Non-Collusion

The Bidder's required signature on the Transmittal Cover Letter for a Proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and services quoted have been established without collusion with other Bidders and without effort to preclude DHHS from obtaining the best possible competitive proposal.

6.9. Collaborative Proposals

Proposals must be submitted by one organization. Any collaborating organization must be designated as subcontractor subject to the terms of Exhibit C Special Provisions (see Appendix B: Contract Minimum Requirements).

6.10. Validity of Proposals

Proposals submitted in response to this RFP must be valid for two hundred forty (240) days following the Technical and Cost Proposal Submission Deadline specified in subsection 6.2, Procurement Timetable or until the effective date of any resulting contract, whichever is later. This period may be extended by mutual written agreement between the Bidder and DHHS.

6.11. Property of Department

All material property submitted and received in response to this RFP will become the property of DHHS and will not be returned to the Bidder. DHHS reserves the right to use any information presented in any Proposal provided that its use does not violate any copyrights or other provisions of law.

6.12. Proposal Withdrawal

Prior to the Technical and Cost Proposal Submission Deadline specified in subsection 6.2, Procurement Timetable, a submitted Letter of Intent or Proposal may be withdrawn by submitting a written request for its withdrawal to the Procurement Coordinator specified in subsection 6.1.

6.13. Public Disclosure

A Proposal must remain confidential until the Governor and Executive Council have approved a contract as a result of this RFP. A Bidder's disclosure or distribution of Proposals other than to the State will be grounds for disqualification.

The content of each Bidder's Proposal, and addenda thereto, will become public information once the Governor and Executive Council have approved a contract. Any information submitted as part of a bid in response to this RFP may be subject to public disclosure under RSA 91-A. In addition, in accordance with RSA 9-F:1, any contract entered into as a result of this RFP will be made accessible to the public online via the website Transparent NH[26]. Accordingly, business financial information and proprietary information such as trade secrets, business and financials models and forecasts, and proprietary formulas may be exempt from public disclosure under RSA 91-A:5, IV.

Insofar as a Bidder seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the Bidder must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. This should be done by separate letter identifying by page number and proposal section number the specific information the Bidder claims to be exempt from public disclosure pursuant to RSA 91-A:5.

Each Bidder acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by a Bidder as confidential, DHHS shall notify the Bidder and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the Bidder's responsibility and at the Bidder's sole expense. If the Bidder fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the Bidder without incurring any liability to the Bidder.

6.14. Non-Commitment

Notwithstanding any other provision of this RFP, this RFP does not commit DHHS to award a contract. DHHS reserves the right to reject any and all Proposals or any portions thereof, at any time and to cancel this RFP and to solicit new Proposals under a new bid process.

6.15. Liability

By submitting a Letter of Intent to submit a Proposal in response to this RFP, a Bidder agrees that in no event shall the State be either responsible for or held liable for any costs incurred by a Bidder in the preparation or submittal of or otherwise in connection with a Proposal, or for work performed prior to the Effective Date of a resulting contract.

[26] Visit: www.nh.gov/transparentnh/

6.16. Request for Additional Information or Materials

During the period from the Technical and Cost Proposal Submission Deadline, specified in subsection 6.2, Procurement Timetable, to the date of Contractor selection, DHHS may request of any Bidder additional information or materials needed to clarify information presented in the Proposal. Such a request will be issued in writing and will not provide a Bidder with an opportunity to change, extend, or otherwise amend its Proposal in intent or substance. Key personnel shall be available for interviews.

6.17. Oral Presentations and Discussions

DHHS reserves the right to require some or all Bidders to make oral presentations of their Proposal. Any and all costs associated with an oral presentation shall be borne entirely by the Bidder. Bidders may be requested to provide demonstrations of any proposed automated systems. Such a request will be in writing and will not provide a Bidder with an opportunity to change, extend, or otherwise amend its proposal in intent or substance.

6.18. Contract Negotiations and Unsuccessful Bidder Notice

If a Bidder(s) is selected, the State will notify the Successful Bidder(s) in writing of their selection and the State's desire to enter into contract negotiations. Until the State successfully completes negotiations with the selected Bidder(s), all submitted Proposals remain eligible for selection by the State. In the event contract negotiations are unsuccessful with the selected Bidder(s), the evaluation team may recommend another Bidder(s).

In accordance with New Hampshire Statutes Chapter 21-I:13-a, no information shall be available to the public, the members of the general court or its staff, notwithstanding the provisions of RSA 91-A:4, concerning specific invitations to bid or other Proposals for public bids, from the time the invitation or proposal is made public until the bid is actually awarded, in order to protect the integrity of the public bidding process. This means unsuccessful Bidders shall not be notified until after the Governor and Executive Council have approved the selected bid awards. No information can be provided to non-selected Bidders until after contracts are awarded, at which time non-selected Bidders may submit a written request for more information about the reasons for not being selected and recommendations that may make future Proposals more effective. Such requests are not considered appeals. Once a Bidder has submitted a letter, DHHS will attempt to accommodate such requests within a reasonable time.

6.19. Scope of Award and Contract Award Notice

DHHS reserves the right to award a service, part of a service, group of services, or total Proposal and to reject any and all Proposals in whole or in part. The notice of the intended contract award will be sent by certified mail or overnight mail to the selected Bidder. A contract award is contingent on approval by the Governor and Executive Council.

If a contract is awarded, the Bidder must obtain written consent from the State before any public announcement or news release is issued pertaining to any contract award.

6.20. Site Visits

DHHS reserves the right to request a site visit for DHHS staff to review a Bidder's organization structure, subcontractors, policy and procedures, and any other aspect of the Proposal that directly affects the provisions of the RFP and the delivery of services. Any and all costs associated with the site visits incurred by the Bidder shall be borne by the Bidder.

Prior to implementation, DHHS reserves the right to make a pre-delegation audit by DHHS staff to the Bidder's site to determine that the Bidder is prepared to initiate required activities. Any and all costs associated with this pre-delegation visit shall be borne by the Bidder.

6.21. Protest of Intended Award

Any protests of intended award or otherwise related to the RFP, shall be governed by the appropriate State requirements and procedures and the terms of this RFP. In the event that a legal action is brought challenging the RFP and selection process, and in the event that the State of New Hampshire prevails, the Bidder agrees to pay all expenses of such action, including attorney's fees and costs at all stages of litigations. Legal action shall include administrative proceedings.

6.22. Contingency

Aspects of the award may be contingent upon changes to State or federal laws and regulations.

7. PROPOSAL OUTLINE AND REQUIREMENTS

7.1. Presentation and Identification

7.1.1. Overview

7.1.1.1. Bidders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal are at the Bidder's risk and may, at the discretion of the State, result in disqualification.

7.1.1.2. Proposals must conform to all instructions, conditions, and requirements included in the RFP.

7.1.1.3. Acceptable Proposals must offer all services identified in Section 3 - Statement of Work, unless an allowance for partial scope is specifically described in Section 3, and agree to the contract conditions specified throughout the RFP.

7.1.1.4. Proposals should be received by the Technical and Cost Proposal Submission Deadline specified in subsection 6.2, Procurement Timetable, and delivered, under sealed cover, to the Procurement Coordinator specified in subsection 6.1.

7.1.1.5. Fax or email copies will not be accepted.

7.1.1.6. Bidders shall submit a Technical Proposal and a Cost Proposal.

7.1.2. Presentation

7.1.2.1. Original copies of Technical and Cost Proposals in separate three-ring binders.

7.1.2.2. Copies in a bound format (for example wire bound, coil bound, saddle stitch, perfect bound etc. at minimum stapled) NOTE: loose Proposals will not be accepted.

7.1.2.3. Major sections of the Proposal separated by tabs.

7.1.2.4. Standard eight and one-half by eleven inch (8 ½" x 11") white paper.

7.1.2.5. Font size of 10 or larger.

7.1.3. Technical Proposal

7.1.3.1. Original in 3 ring binder marked as "Original."

7.1.3.2. The original Transmittal Letter (described in subsection 7.2.2.1) must be the first page of the Technical Proposal and marked as "Original."

7.1.3.3. 4 copies in bound format marked as "Copy."

7.1.3.4. 1 electronic copy (divided into folders that correspond to and are labeled the same as the hard copies). on CD or Memory Card/Thumb Drive. NOTE: In the event of any discrepancy between the copies, the hard copy marked "Original" will control.

7.1.3.5. Front cover labeled with:

a. Name of company / organization;
b. RFP#; and
c. Technical Proposal.

7.1.4. Cost Proposal

7.1.4.1. Original in 3 ring binder marked as "Original."

7.1.4.2. A copy of the Transmittal Letter marked as "Copy" as the first page of the Cost Proposal.

7.1.4.3. 2 copies in bound format marked as "Copy."

7.1.4.4. 1 electronic copy (divided into folders that correspond to and are labeled the same as the hard copies). NOTE: In the event of any discrepancy between the copies, the hard copy marked "Original" will control.

7.1.4.5. Front cover labeled with:

a. Name of company / organization;
b. RFP#; and
c. Cost Proposal.

7.2. Outline and Detail

7.2.1. Proposal Contents – Outline

Each Proposal shall contain the following, in the order described in this section: (Each of these components must be separate from the others and uniquely identified with labeled tabs.)

7.2.2. Technical Proposal Contents – Detail

7.2.2.1. Transmittal Cover Letter

The Transmittal Cover Letter must be:

a. On the Bidding company's letterhead;
b. Signed by an individual who is authorized to bind the Bidding Company to all statements, including services and prices contained in the Proposal; and
c. Contain the following:
   i. Identify the submitting organization;
   ii. Identify the name, title, mailing address, telephone number and email address of the person authorized by the organization to contractually obligate the organization;
   iii. Identify the name, title, mailing address, telephone number and email address of the fiscal agent of the organization;
   iv. Identify the name, title, telephone number, and e-mail address of the person who will serve as the Bidder's representative for all matters relating to the RFP;
   v. Acknowledge that the Bidder has read this RFP, understands it, and agrees to be bound by its requirements;
   vi. Explicitly state acceptance of terms, conditions, and general instructions stated in Section 8 Mandatory Business Specifications, Contract Terms and Conditions;
   vii. Confirm that Appendix A Exceptions to Terms and Conditions is included in the proposal;
   viii. Explicitly state that the Bidder's submitted Proposal is valid for a minimum of two hundred forty (240) days from the Technical and Cost Proposal Submission Deadline specified in subsection 6.2;
   ix. Date Proposal was submitted; and
   x. Signature of authorized person.

7.2.2.2. Table of Contents

The required elements of the Proposal shall be numbered sequentially and represented in the Table of Contents.

7.2.2.3. Executive Summary

The Bidder shall submit an executive summary to:

a. Provide DHHS with an overview of the Bidder's organization and what is intended to be provided by the Bidder;
b. Demonstrate the Bidder's understanding of the services requested in this RFP and any problems anticipated in accomplishing the work;
c. Show the Bidder's overall design of the project in response to achieving the deliverables as defined in this RFP; and
d. Specifically demonstrate the Bidder's familiarity with the project elements, its solutions to the problems presented and knowledge of the requested services.

7.2.2.4. Proposal Narrative, Project Approach, and Technical Response

The Bidder must answer all questions and must include all items requested for the Proposal to be considered. The Bidder must address every section of Section 3 Statement of Work, even though certain sections may not be scored.

Responses must be in the same sequence and format as listed in Section 3 Statement of Work and must, at a minimum, cite the relevant section, subsection, and paragraph number, as appropriate.

7.2.2.5. Description of Organization

Bidders must include in their Proposal a summary of their company's organization, management and history and how the organization's experience demonstrates the ability to meet the needs of requirements in this RFP.

a. At a minimum respond to:
   i. General company overview;
   ii. Ownership and subsidiaries;
   iii. Company background and primary lines of business;
   iv. Number of employees;
   v. Headquarters and Satellite Locations;
   vi. Current project commitments;
   vii. Major government and private sector clients; and
   viii. Mission Statement.
b. This section must include information on:
   i. The programs and activities of the organization;
   ii. The number of people served; and
   iii. Programmatic accomplishments.
c. And also include:
   i. Reasons why the organization is capable of effectively completing the services outlined in the RFP; and
   ii. All strengths that are considered an asset to the program.
d. The Bidder should demonstrate:
   i. The length, depth, and applicability of all prior experience in providing the requested services;
   ii. The skill and experience of staff and the length, depth and applicability of all prior experience in providing the requested services.

7.2.2.6. Bidder's References

The Proposal must include relevant information about at least three (3) similar or related contracts or subcontracts awarded to the Bidder and must also include client testimonials. Particular emphasis should be placed on previous contractual experience with government agencies. DHHS reserves the right to contact any reference so identified. The information must contain the following:

a. Name, address, telephone number, and website of the customer;
b. A description of the work performed under each contract;
c. A description of the nature of the relationship between the Bidder and the customer;
d. Name, telephone number, and e-mail address of the person whom DHHS can contact as a reference; and
e. Dates of performance.

7.2.2.7. Staffing and Resumes

Each Bidder shall submit an organizational chart and a staffing plan for the program. For persons currently on staff with the Bidder, the Bidder shall provide names, title, qualifications and resumes. For staff to be hired, the Bidder shall describe the hiring process and the qualifications for the position and the job description. The State reserves the right to accept or reject dedicated staff individuals.

7.2.2.8. Subcontractor Letters of Commitment (if applicable)

If subcontractors are part of this proposal, signed letters of commitment from the subcontractor are required as part of the RFP. The Bidder shall be solely responsible for meeting all requirements and terms and conditions specified in this RFP, its Proposal, and any resulting contract, regardless of whether it proposes to use any subcontractors. The Bidder and any subcontractors shall commit to the entire contract period stated within the RFP, unless a change of subcontractors is specifically agreed to by the State. The State reserves the right to approve or reject subcontractors for this project and to require the Bidder to replace subcontractors found to be unacceptable.

7.2.2.9. License, Certificates and Permits as Required

This includes: a Certificate of Good Standing or assurance of obtaining registration with the New Hampshire Office of the Secretary of State. Required licenses or permits to provide services as described in Section 3 of this RFP.

7.2.2.10. Affiliations – Conflict of Interest

The Bidder must include a statement regarding any and all affiliations that might result in a conflict of interest. Explain the relationship and how the affiliation would not represent a conflict of interest.

7.2.2.11. Required Attachments

The following are required statements that must be included with the Proposal. The Bidder must complete the correlating forms found in the RFP Appendices and submit them as the “Required Attachments” section of the Proposal.

a. Bidder Information and Declarations: Exceptions to Terms and Conditions, Appendix A
b. CLAS Requirements – Appendix C

7.2.3. Cost Proposal Contents – Detail

7.2.3.1. Cost Bid Requirements

Cost proposals may be adjusted based on the final negotiations of the scope of work. See Section 4, Finance for specific requirements.

7.2.3.2. Statement of Bidder’s Financial Condition

The organization’s financial solvency will be evaluated. The Bidder’s ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered.

Each Bidder must submit audited financial statements for the four (4) most recently completed fiscal years that demonstrate the Bidder's organization is in sound financial condition. Statements must include a report by an independent auditor that expresses an unqualified or qualified opinion as to whether the accompanying financial statements are presented fairly in accordance with generally accepted accounting principles. A disclaimer of opinion, an adverse opinion, a special report, a review report, or a compilation report will be grounds for rejection of the proposal.

Complete financial statements must include the following:

a. Opinion of Certified Public Accountant
b. Balance Sheet
c. Income Statement
d. Statement of Cash Flow
e. Statement of Stockholder's Equity of Fund Balance
f. Complete Financial Notes
g. Consolidating and Supplemental Financial Schedules

A Bidder, which is part of a consolidated financial statement, may file the audited consolidated financial statements if it includes the consolidating schedules as supplemental information. A Bidder, which is part of a consolidated financial statement, but whose certified consolidated financial statements do not contain the consolidating schedules as supplemental information, shall, in addition to the audited consolidated financial statements, file unaudited financial statements for the Bidder alone accompanied by a certificate of authenticity signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification which attests that the financial statements are correct in all material respects.

If a bidder is not otherwise required by either state or federal statute to obtain a certification of audit of its financial statements, and thereby elects not to obtain such certification of audit, the bidder shall submit as part of its proposal:

a. Uncertified financial statements; and
b. A certificate of authenticity which attests that the financial statements are correct in all material respects and is signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification.

7.2.3.3. Required Attachments

The following are required statements that must be included with the Proposal. The Bidder must complete the correlating forms found in the RFP Appendices and submit them as the "Required Attachments" section of the Proposal.

a. Bidder Information and Declarations:
   i. Budget – Appendix D, for each program area and each SFY
   ii. Budget Narrative – for each program area and each SFY
   iii. Program Staff List – Appendix E, for each program area and each SFY

8. MANDATORY BUSINESS SPECIFICATIONS

8.1. Contract Terms, Conditions and Penalties, Forms

8.1.1. Contract Terms and Conditions

The State of New Hampshire sample contract is attached; Bidder to agree to minimum requirement as set forth in the Appendix B.

8.1.2. Penalties

The State intends to negotiate with the awarded vendor to include liquidated damages in the contract in the event any deliverables are not met.

The Department and the Contractor agree that the actual damages that the Department will sustain in the event the Contractor fails to maintain the required performance standards throughout the life of the contract will be uncertain in amount and difficult and impracticable to determine. The Contractor acknowledges and agrees that any failure to achieve required performance levels by the Contractor will more than likely substantially delay and disrupt the Department's operations. Therefore the parties agree that liquidated damages shall be determined as part of the contract specifications.

Assessment of liquidated damages shall be in addition to, and not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages applicable to any given incident.

The Department will determine compliance and assessment of liquidated damages as often as it deems reasonably necessary to ensure required performance standards are met. Amounts due the State as liquidated damages may be deducted by the State from any fees payable to the Contractor and any amount outstanding over and above the amounts deducted from the invoice will be promptly tendered by check from the Contractor to the State.

9. ADDITIONAL INFORMATION

9.1. Appendix A – Exceptions to Terms and Conditions
9.2. Appendix B – Contract Minimum Requirements
9.3. Appendix C – CLAS Requirements
9.4. Appendix D – Budget
9.5. Appendix E – Program Staff List
9.6. Appendix F – Ten Essential Public Health Services
9.7. Appendix G – Greater Derry Public Health Network Region
9.8. Appendix H – RPHN Region Map
9.9. Appendix I – Hazard Vulnerability Assessment
9.10. Appendix J – MCM ORR Provisional Guide

APPENDIX A

EXCEPTIONS TO TERMS AND CONDITIONS

A Responder shall be presumed to be in agreement with the terms and conditions of the RFP unless the Responder takes specific exception to one or more of the conditions on this form.

RESPONDERS ARE CAUTIONED THAT BY TAKING ANY EXCEPTION THEY MAY BE MATERIALLY DEVIATING FROM THE RFP SPECIFICATIONS. IF A RESPONDER MATERIALLY DEVIATES FROM A RFP SPECIFICATION, ITS PROPOSAL MAY BE REJECTED.

A material deviation is an exception to a specification which 1) affords the Responder taking the exception a competitive advantage over other Responders, or 2) gives the State something significantly different than the State requested.

INSTRUCTIONS: Responders must explicitly list all exceptions to State of NH minimum terms and conditions. Reference the actual number of the State's term and condition and Exhibit number for which an exception(s) is being taken. If no exceptions exist, state "NONE" specifically on the form below. Whether or not exceptions are taken, the Responder must sign and date this form and submit it as part of their Proposal. (*Add additional pages if necessary*.)

Responder Name:	
Term & Condition Number/Provision	**Explanation of Exception**

By signing this form, I acknowledge that the above named Responder accepts, without qualification, all terms and conditions stated in this RFP Section 8- Mandatory Business Specifications, Contract Terms and Conditions except those clearly outlined as exceptions above.

_____ _____ _____

Signature Title Date

FORM NUMBER P-37 (version 5/8/15)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

<table>
<tr><td colspan="2">1.1 State Agency Name</td><td colspan="2">1.2 State Agency Address</td></tr>
<tr><td colspan="2">1.3 Contractor Name</td><td colspan="2">1.4 Contractor Address</td></tr>
<tr><td>1.5 Contractor Phone Number</td><td>1.6 Account Number</td><td>1.7 Completion Date</td><td>1.8 Price Limitation</td></tr>
<tr><td colspan="2">1.9 Contracting Officer for State Agency</td><td colspan="2">1.10 State Agency Telephone Number</td></tr>
<tr><td colspan="2">1.11 Contractor Signature</td><td colspan="2">1.12 Name and Title of Contractor Signatory</td></tr>
<tr><td colspan="4">1.13 Acknowledgement: State of , County of

On , before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.</td></tr>
<tr><td colspan="4">1.13.1 Signature of Notary Public or Justice of the Peace

[Seal]</td></tr>
<tr><td colspan="4">1.13.2 Name and Title of Notary or Justice of the Peace</td></tr>
<tr><td colspan="2">1.14 State Agency Signature

Date:</td><td colspan="2">1.15 Name and Title of State Agency Signatory</td></tr>
<tr><td colspan="4">1.16 Approval by the N.H. Department of Administration, Division of Personnel (if applicable)

By: Director, On:</td></tr>
<tr><td colspan="4">1.17 Approval by the Attorney General (Form, Substance and Execution) (if applicable)

By: On:</td></tr>
<tr><td colspan="4">1.18 Approval by the Governor and Executive Council (if applicable)

By: On:</td></tr>
</table>

2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials _____
Date_____

Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.
9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.
The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials _____
Date_____

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.
15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.
15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. **WAIVER OF BREACH.** No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials _____
Date_____

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

_____ _____

Date Name:
Title:

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor Name:

_____ _____

Date

Name:
Title:

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions,” without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

_____ Date

_____ Name:
Title:

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

_____ _____

Date

Name:
Title:

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

_____ _____

Date Name:
Title:

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) l, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

_____	_____
The State	Name of the Contractor
_____	_____
Signature of Authorized Representative	Signature of Authorized Representative
_____	_____
Name of Authorized Representative	Name of Authorized Representative
_____	_____
Title of Authorized Representative	Title of Authorized Representative
_____	_____
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

_____ _____

Date

Name:
Title:

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: _____

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   _____ NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

APPENDIX C

Addendum to Culturally and Linguistically Appropriate Services (CLAS) Section of RFP for Purpose of Documenting Title VI Compliance

All DHHS bidders are required to complete the following two (2) steps as part of their proposal:

(1) Perform an individualized organizational assessment, using the four-factor analysis, to determine the extent of language assistance to provide for programs, services and/or activities; and;
(2) Taking into account the outcome of the four-factor analysis, respond to the questions below.

Background:

Title VI of the Civil Rights Act of 1964 and its implementing regulations provide that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program that receives Federal financial assistance. The courts have held that national origin discrimination includes discrimination on the basis of limited English proficiency. Any organization or individual that receives Federal financial assistance, through either a grant, contract, or subcontract is a covered entity under Title VI. Examples of covered entities include the NH Department of Health and Human Services and its contractors.

Covered entities are required to take reasonable steps to ensure ***meaningful access*** by persons with limited English proficiency (LEP) to their programs and activities. LEP persons are those with a limited ability to speak, read, write or understand English.

The **key** to ensuring meaningful access by LEP persons is effective communication. An agency or provider can ensure effective communication by developing and implementing a language assistance program that includes policies and procedures for identifying and assessing the language needs of its LEP clients/applicants, and that provides for an array of language assistance options, notice to LEP persons of the right to receive language assistance free of charge, training of staff, periodic monitoring of the program, and translation of certain written materials.

The Office for Civil Rights (OCR) is the federal agency responsible for enforcing Title VI. OCR recognizes that covered entities vary in size, the number of LEP clients needing assistance, and the nature of the services provided. Accordingly, covered entities have some flexibility in how they address the needs of their LEP clients. (In other words, it is understood that one size language assistance program does not fit all covered entities.)

The **starting point** for covered entities to determine the extent of their obligation to provide LEP services is to apply a four-factor analysis to their organization. It is important to understand that the flexibility afforded in addressing the needs of LEP clients ***does not diminish*** the obligation covered entities have to address those needs.

APPENDIX C

Examples of practices that may violate Title VI include:

- Limiting participation in a program or activity due to a person's limited English proficiency;
- Providing services to LEP persons that are more limited in scope or are lower in quality than those provided to other persons (such as then there is no qualified interpretation provided);
- Failing to inform LEP persons of the right to receive free interpreter services and/or requiring LEP persons to provide their own interpreter;
- Subjecting LEP persons to unreasonable delays in the delivery of services.

BIDDER STEP #1 – Individualized Assessment Using Four-Factor Analysis

The four-factor analysis helps an organization determine the right mix of services to provide to their LEP clients. The right mix of services is based upon an individualized assessment, involving the balancing of the following four factors.

(1) The **number** or proportion of LEP persons served or likely to be encountered in the population that is eligible for the program;
(2) The **frequency** with which LEP individuals come in contact with the program, activity or service;
(3) The **importance** or impact of the contact upon the lives of the person(s) served by the program, activity or service;
(4) The **resources** available to the organization to provide effective language assistance.

This addendum was created to facilitate bidders' application of the four-factor analysis to the services they provide. At this stage, bidders are not required to submit their four-factor analysis as part of their proposal. **However, successful bidders will be required to submit a detailed description of the language assistance services they will provide to LEP persons to ensure meaningful access to their programs and/or services, within 10 days of the date the contract is approved by Governor and Council.** For further guidance, please see the Bidder's Reference for Completing the Culturally and Linguistically Appropriate Services (CLAS) Section of the RFP, which is available in the Vendor/RFP Section of the DHHS website.

APPENDIX C

Important Items to Consider When Evaluating the Four Factors.

Factor #1 The number or proportion of LEP persons served or encountered in the population that is eligible for the program.

Considerations:

- The eligible population is specific to the program, activity or service. It includes LEP persons serviced by the program, as well as those directly affected by the program, activity or service.
- Organizations are required not only to examine data on LEP persons served by their program, but also those in the community who are ***eligible*** for the program (but who are not currently served or participating in the program due to existing language barriers).
- Relevant data sources may include information collected by program staff, as well as external data, such as the latest Census Reports.
- Recipients are required to apply this analysis to each language in the service area. When considering the number or proportion of LEP individuals in a service area, recipients should consider whether the minor children their programs serve have LEP parent(s) or guardian(s) with whom the recipient may need to interact. It is also important to consider language minority populations that are eligible for the programs or services, but are not currently served or participating in the program, due to existing language barriers.
- An effective means of determining the number of LEP persons served is to record the preferred languages of people who have day-to-day contact with the program.
- It is important to remember that the ***focus*** of the analysis is on the lack of English proficiency, not the ability to speak more than one language.

Factor #2: The frequency with which LEP individuals come in contact with the program, activity or service.

- The more frequently a recipient entity has contact with individuals in a particular language group, the more likely that language assistance in that language is needed. For example, the steps that are reasonable for a recipient that serves an LEP person on a one-time basis will be very different from those that are expected from a recipient that serves LEP persons daily.
- Even recipients that serve people from a particular language group infrequently or on an unpredictable basis should use this four-factor analysis to determine what to do if an LEP person seeks services from their program.
- The resulting plan may be as simple as being prepared to use a telephone interpreter service.
- The key is to have a plan in place.

Factor #3 The importance or impact of the contact upon the lives of the person(s) served by the program, activity or service.
• The more important a recipient's activity, program or service, or the greater the possible consequence of the contact to the LEP persons, the more likely language services are needed. • When considering this factor, the recipient should determine both the importance, as well as the urgency of the service. For example, if the communication is both important and urgent (such as the need to communicate information about an emergency medical procedure), it is more likely that immediate language services are required. If the information to be communicated is important but not urgent (such as the need to communicate information about elective surgery, where delay will not have any adverse impact on the patient's health), it is likely that language services are required, but that such services can be delayed for a reasonable length of time.
Factor #4 The resources available to the organization to provide effective language assistance.
• A recipient's level of resources and the costs of providing language assistance services is another factor to consider in the analysis. • Remember, however, that cost is merely one factor in the analysis. Level of resources and costs do not diminish the requirement to address the need, however they may be considered in determining how the need is addressed; • Resources and cost issues can often be reduced, for example, by sharing language assistance materials and services among recipients. Therefore, recipients should carefully explore the most cost-effective means of delivering quality language services prior to limiting services due to resource limitations.

APPENDIX C

BIDDER STEP #2 - Required Questions Relating to Language Assistance Measures

Taking into account the four-factor analysis, please answer the following questions in the six areas of the table below. (**Do not** attempt to answer the questions until you have completed the four-factor analysis.) The Department understands that your responses will depend on the outcome of the four-factor analysis. The requirement to provide language assistance does not vary, but the measures taken to provide the assistance will necessarily differ from organization to organization.

1. IDENTIFICATION OF LEP PERSONS SERVED OR LIKELY TO BE ENCOUNTERED IN YOUR PROGRAM		
a. Do you make an effort to identify LEP persons served in your program? (One way to identify LEP persons served in your program is to collect data on ethnicity, race, and/or preferred language.)	Yes	No
b. Do you make an effort to identify LEP persons likely to be encountered in the population eligible for your program or service? (One way to identify LEP persons likely to be encountered is by examining external data sources, such as Cenus data)	Yes	No
c. Does you make an effort to use data to identify new and emerging population or community needs?	Yes	No
2. NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE		
Do you inform all applicants / clients of their right to receive language / communication assistance services at no cost? **(Or, do you have procedures in place to notify LEP applicants / clients of their right to receive assistance, if needed?)** Example: One way to notify clients about the availability of language assistance is through the use of an "I Speak" card.	Yes	No
3. STAFF TRAINING		
Do you provide training to personnel at all levels of your organization on federal civil rights laws compliance and the procedures for providing language assistance to LEP persons, if needed?	Yes	No

4. PROVISION OF LANGUAGE ASSISTANCE		
Do you provide language assistance to LEP persons, free of charge, in a timely manner? **(Or, do you have procedures in place to provide language assistance to LEP persons, if needed)**	Yes	No

APPENDIX C

In general, covered entities are required to provide two types of language assistance: (1) oral interpretation and (2) translation of written materials. Oral interpretation may be carried out by contracted in-person or remote interpreters, and/or bi-lingual staff. (Examples of written materials you may need to translate include vital documents such as consent forms and statements of rights.)			
5. ENSURING COMPETENCY OF INTERPRETERS USED IN PROGRAM AND THE ACCURACY OF TRANSLATED MATERIALS			
a. Do you make effort to assess the language fluency of all interpreters used in your program to determine their level of competence in their specific field of service? (Note: A way to fulfill this requirement is to use certified interpreters only.)	Yes	No	
b. As a general rule, does your organization avoid the use of family members, friends, and other untested individual to provide interpretation services?	Yes	No	
c. Does your organization have a policy and procedure in place to handle client requests to use a family member, friend, or other untested individual to provide interpretation services?	Yes	No	
d. Do you make an effort to verify the accuracy of any translated materials used in your program (or use only professionally certified translators)? (Note: Depending on the outcome of the four-factor analysis, N/A (Not applicable) may be an acceptable response to this question.	Yes	No	N/A
6. MONITORING OF SERVICES PROVIDED			
Does you make an effort to periodically evaluate the effectiveness of any language assistance services provided, and make modifications, as needed?	Yes		No
If there is a designated staff member who carries out the evaluation function? If so, please provide the person's title: _____	Yes		No

By signing and submitting this attachment to RFP#_____, the Contractor affirms that it:

1.) Has completed the four-factor analysis as part of the process for creating its proposal, in response to the above referenced RFP.
2.) Understands that Title VI of the Civil Rights Act of 1964 requires the Contractor to take reasonable steps to ensure meaningful access to ***all*** LEP persons to all programs, services, and/or activities offered by my organization.

3.) Understands that, if selected, the Contractor will be required to submit a detailed description of the language assistance services it will provide to LEP persons to ensure meaningful access to programs and/or services, within 10 days of the date the contract is approved by Governor and Council.

Contractor/Vendor Signature	Contractor's Representative Name/Title
Contractor Name	Date

BUDGET FORM WITH MATCH

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Bidder Name: _____

Budget Request for: Regional Public Health Network Services for the Greater Derry Region
(Name of RFP)

Budget Period: SFY 2016 (date of G&C Approval - 6/30/16)

Line Item	Direct Incremental	Indirect Fixed	Total	Cash Match	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ -	$ -	$ -	$ -	
2. Employee Benefits	$ -	$ -	$ -	$ -	
3. Consultants	$ -	$ -	$ -	$ -	
4. Equipment:	$ -	$ -	$ -	$ -	
Rental	$ -	$ -	$ -	$ -	
Repair and Maintenance	$ -	$ -	$ -	$ -	
Purchase/Depreciation	$ -	$ -	$ -	$ -	
5. Supplies:	$ -	$ -	$ -	$ -	
Educational	$ -	$ -	$ -	$ -	
Lab	$ -	$ -	$ -	$ -	
Pharmacy	$ -	$ -	$ -	$ -	
Medical	$ -	$ -	$ -	$ -	
Office	$ -	$ -	$ -	$ -	
6. Travel	$ -	$ -	$ -	$ -	
7. Occupancy	$ -	$ -	$ -	$ -	
8. Current Expenses	$ -	$ -	$ -	$ -	
Telephone	$ -	$ -	$ -	$ -	
Postage	$ -	$ -	$ -	$ -	
Subscriptions	$ -	$ -	$ -	$ -	
Audit and Legal	$ -	$ -	$ -	$ -	
Insurance	$ -	$ -	$ -	$ -	
Board Expenses	$ -	$ -	$ -	$ -	
9. Software	$ -	$ -	$ -	$ -	
10. Marketing/Communications	$ -	$ -	$ -	$ -	
11. Staff Education and Training	$ -	$ -	$ -	$ -	
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	
TOTAL	**$ -**	**$ -**	**$ -**	**$ -**	

Indirect As A Percent of Direct #DIV/0!

NOTE: Minimum match funding per section 4.4 of RFP

BUDGET FORM WITH MATCH

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Bidder Name: _____

Budget Request for: Regional Public Health Network Services for the Greater Derry Region
(Name of RFP)

Budget Period: SFY 2017 (July 1, 2016 - 6/30/17)

Line Item	Direct Incremental	Indirect Fixed	Total	Cash Match	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ -	$ -	$ -	$ -	
2. Employee Benefits	$ -	$ -	$ -	$ -	
3. Consultants	$ -	$ -	$ -	$ -	
4. Equipment:	$ -	$ -	$ -	$ -	
Rental	$ -	$ -	$ -	$ -	
Repair and Maintenance	$ -	$ -	$ -	$ -	
Purchase/Depreciation	$ -	$ -	$ -	$ -	
5. Supplies:	$ -	$ -	$ -	$ -	
Educational	$ -	$ -	$ -	$ -	
Lab	$ -	$ -	$ -	$ -	
Pharmacy	$ -	$ -	$ -	$ -	
Medical	$ -	$ -	$ -	$ -	
Office	$ -	$ -	$ -	$ -	
6. Travel	$ -	$ -	$ -	$ -	
7. Occupancy	$ -	$ -	$ -	$ -	
8. Current Expenses	$ -	$ -	$ -	$ -	
Telephone	$ -	$ -	$ -	$ -	
Postage	$ -	$ -	$ -	$ -	
Subscriptions	$ -	$ -	$ -	$ -	
Audit and Legal	$ -	$ -	$ -	$ -	
Insurance	$ -	$ -	$ -	$ -	
Board Expenses	$ -	$ -	$ -	$ -	
9. Software	$ -	$ -	$ -	$ -	
10. Marketing/Communications	$ -	$ -	$ -	$ -	
11. Staff Education and Training	$ -	$ -	$ -	$ -	
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	
TOTAL	**$ -**	**$ -**	**$ -**	**$ -**	

Indirect As A Percent of Direct #DIV/0!

NOTE: Minimum match funding per section 4.4 of RFP

Program Staff List

New Hampshire Department of Health and Human Services

COMPLETE ONE PROGRAM STAFF LIST FOR EACH STATE FISCAL YEAR

Proposal Agency Name:
Program: Regional Public Health Network Services for the Greater Derry Area
Budget Period: SFY 2016 (date of G&C Approval - 6/30/16)

A	B	C	D	E	E	F
Position Title	Current Individual in Position	Projected Hrly Rate as of 1st Day of Budget Period	Hours per Week	Amnt Funded by this program for Budget Period	Amnt Funded by other sources for Budget Period	Site*
Example:						
Program Coordinator	Sandra Smith	$21.00	40	$43,680	$43,680	
Administrative Salaries						
Total Admin. Salaries				$0	$0	
Direct Service Salaries						
Total Direct Salaries				$0	$0	
Total Salaries by Program				$0.00	$0.00	

Please note, any forms downloaded from the DHHS website will NOT calculate. Forms will be sent electronically via e-mail to all programs submitting a Letter of Intent by the due date.
*Please list which site(s) each staff member works at, if your agency has multiple sites.

Program Staff List

New Hampshire Department of Health and Human Services

COMPLETE ONE PROGRAM STAFF LIST FOR EACH STATE FISCAL YEAR

Proposal Agency Name:
Program: Regional Public Health Network Services for the Greater Derry Area
Budget Period: SFY 2017 (7/1/16 - 6/30/17)

A	B	C	D	E	E	F
Position Title	Current Individual in Position	Projected Hrly Rate as of 1st Day of Budget Period	Hours per Week	Amnt Funded by this program for Budget Period	Amnt Funded by other sources for Budget Period	Site*
Example:						
Program Coordinator	Sandra Smith	$21.00	40	$43,680	$43,680	
Administrative Salaries						
Total Admin. Salaries				$0	$0	
Direct Service Salaries						
Total Direct Salaries				$0	$0	
Total Salaries by Program				$0.00	$0.00	

Please note, any forms downloaded from the DHHS website will NOT calculate. Forms will be sent electronically via e-mail to all programs submitting a Letter of Intent by the due date.
*Please list which site(s) each staff member works at, if your agency has multiple sites.

APPENDIX F

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*

The Ten Essential Public Health Services

The **Ten Essential Public Health Services** describe the public health activities that should be undertaken in all communities and were developed as a companion to the three core public health functions. In their 1988 report, The Future of Public Health, the Institutes of Medicine (IOM) defined the three core functions of governmental public health as assessment, policy development, and assurance. The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

1. **Monitor** health status to identify and solve community health problems.

2. **Diagnose and investigate** health problems and health hazards in the community.

3. **Inform, educate, and empower** people about health issues.

4. **Mobilize** community partnerships and action to identify and solve health problems.

5. **Develop policies and plans** that support individual and community health efforts.

6. **Enforce** laws and regulations that protect health and ensure safety.

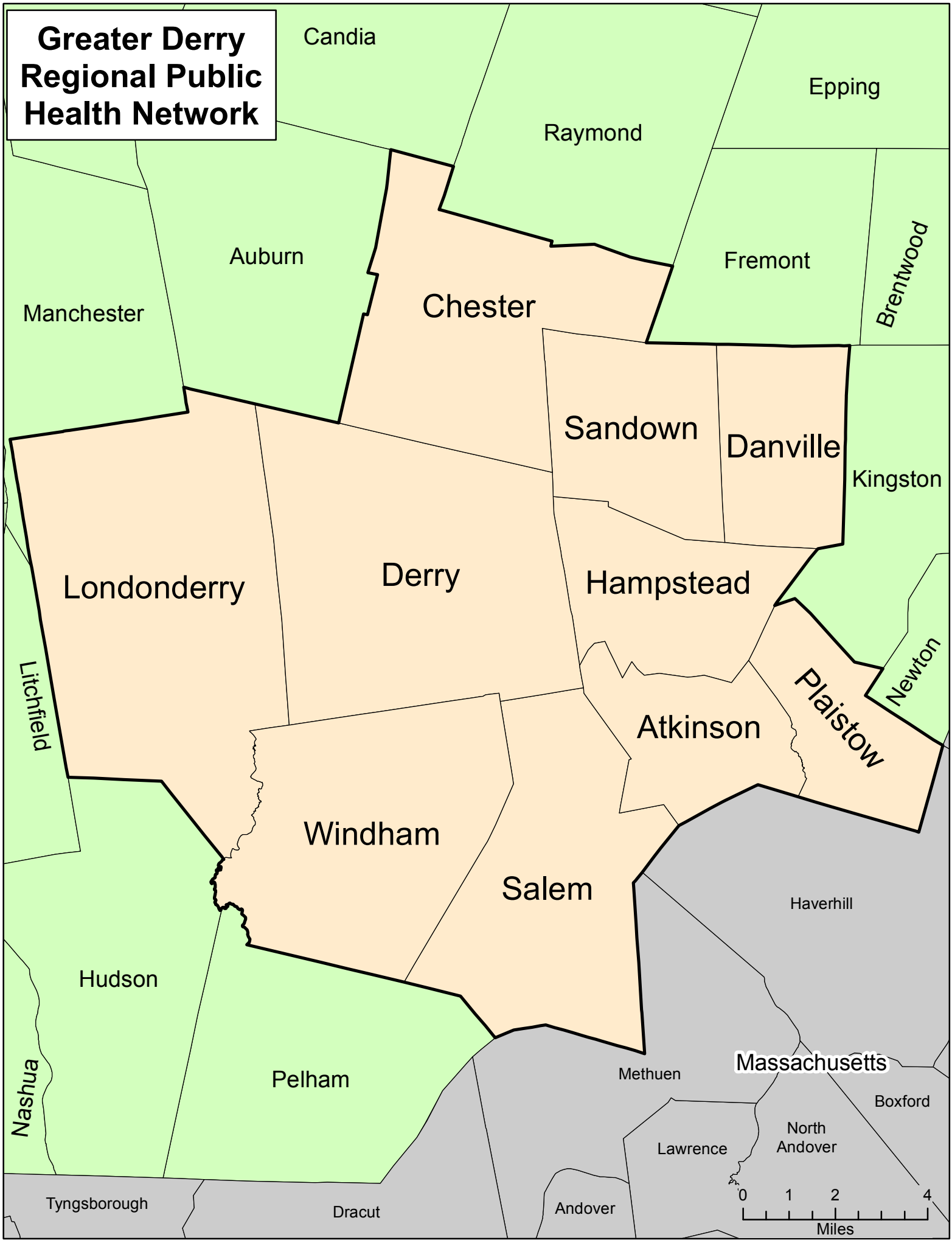
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.

8. **Assure** competent public and personal health care workforce.

9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.

10. **Research** for new insights and innovative solutions to health problems.

Adapted from the Centers for Disease Control and Prevention, National Public Health Performance Standards Program at: http://www.phppo.cdc.gov/nphpsp/10EssentialPHServices.asp Accessed 9-29-04

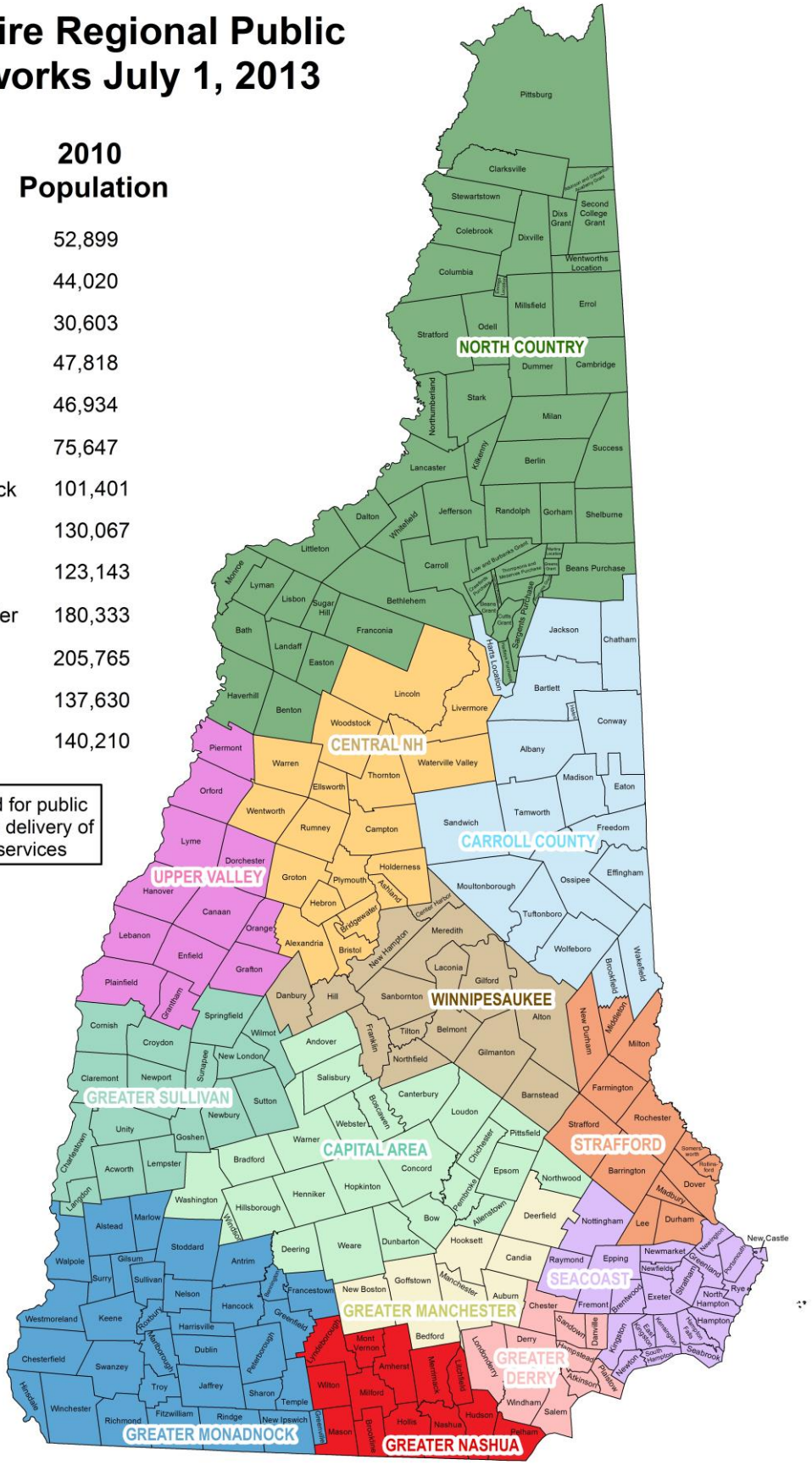

Greater Derry Regional Public Health Network
Candia
Raymond
Epping
Auburn
Fremont
Brentwood
Manchester
Chester
Sandown
Danville
Kingston
Londonderry
Derry
Hampstead
Newton
Litchfield
Plaistow
Atkinson
Windham
Salem
Haverhill
Hudson
Nashua
Pelham
Massachusetts
Methuen
Boxford
North Andover
Lawrence
Tyngsborough
Dracut
Andover
0 1 2 4
Miles

APPENDIX H

New Hampshire Regional Public Health Networks July 1, 2013

Region	2010 Population
North Country	52,899
Upper Valley	44,020
Central NH	30,603
Carroll County	47,818
Greater Sullivan	46,934
Winnipesaukee	75,647
Greater Monadnock	101,401
Capital Area	130,067
Strafford County	123,143
Greater Manchester	180,333
Greater Nashua	205,765
Greater Derry	137,630
Seacoast	140,210

These regions are used for public health planning and the delivery of select public health services



APPENDIX H

TOWN LIST

REGION NAME	TOWN
North County	Atkinson and Gilmanton Academy Grant, Bath, Beans Grant, Beans Purchase, Benton, Berlin, Bethlehem, Cambridge, Carroll, Chandlers Purchase, Clarksville, Colebrook, Columbia, Crawfords Purchase, Cutts Grant, Dalton, Dixs Grant, Dixville, Dummer, Easton, Errol, Ervings Location, Franconia, Gorham, Greens Grant, Hadleys Purchase, Haverhill, Jefferson, Kilkenney, Lancaster, Landaff, Lisbon, Littleton, Low and Burbank's Grant, Lyman, Martins Location, Milan, Millsfield, Monroe, Northumberland, Odell, Pinkham's Grant, Pittsburg, Randolph, Sargents Purchase, Second College Grant, Shelburne, Stark, Stewartstown, Stratford, Success, Sugar Hill, Thompsons & Meserves Purchase, Wentworths Location, Whitefield
Upper Valley	Canaan, Dorchester, Enfield, Grafton, Grantham, Hanover, Lebanon, Lyme, Orange, Orford, Piermont, Plainfield
Central NH	Alexandria, Ashland, Bridgewater, Bristol, Campton, Ellsworth, Groton, Hebron, Holderness, Lincoln, Livermore, Plymouth, Rumney, Thornton, Warren, Waterville Valley, Wentworth, Woodstock
Carroll County	Albany, Bartlett, Brookfield, Chatham, Conway, Eaton, Effingham, Freedom, Hale's Location, Harts Location, Jackson, Madison, Moultonborough, Ossipee, Sandwich, Tamworth, Tuftonboro, Wakefield, Wolfeboro
Greater Sullivan	Acworth, Charlestown, Claremont, Cornish, Croydon, Goshen, Langdon, Lempster, Newbury, New London, Newport, Springfield, Sunapee, Sutton, Unity, Wilmot
Winnipesaukee	Alton, Barnstead, Belmont, Center Harbor, Danbury, Franklin, Gilford, Gilmanton, Hill, Laconia, Meredith, New Hampton, Northfield, Sanbornton, Tilton
Greater Monadnock	Alstead, Antrim, Bennington, Chesterfield, Dublin, Fitzwilliam, Francestown, Gilsum, Greenfield, Greenville, Hancock, Harrisville, Hinsdale, Jaffrey, Keene, Marlborough, Marlow, Nelson, New Ipswich, Peterborough, Richmond, Rindge, Roxbury, Sharon, Stoddard, Sullivan, Surry, Swanzey, Temple, Troy, Walpole, Westmoreland, Winchester
Capital	Allenstown, Andover, Boscawen, Bow, Bradford, Canterbury, Chichester, Concord, Deering, Dunbarton, Epsom, Henniker, Hillsborough, Hopkinton, Loudon, Northwood, Pembroke, Pittsfield, Salisbury, Warner, Washington, Weare, Webster, Windsor
Strafford County	Barrington, Dover, Durham, Farmington, Lee, Madbury, Middleton, Milton, New Durham, Rochester, Rollinsford, Somersworth, Strafford
Greater Manchester	Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Manchester, New Boston
Greater Nashua	Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Mason, Merrimack, Milford, Mont Vernon, Nashua, Pelham, Wilton
Greater Derry	Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Salem, Sandown, Windham
Seacoast	Brentwood, East Kingston, Epping, Exeter, Fremont, Greenland, Hampton, Hampton Falls, Kensington, Kingston, New Castle, Newfields, Newington,

	Newmarket, Newton, North Hampton, Nottingham, Portsmouth, Raymond, Rye, Seabrook, South Hampton, Stratham

Boston MSA Hazard Vulnerability Assessment
Rockingham County Action Plan

Strategy 1: Develop regional volunteer coordination plan.

Desired outcome: Increase % of volunteer organizations that participate in coordinated response during incidents and exercises; develop standardized training requirements, increase opportunities for shared training, and develop a coordinated mechanism to communicate with and activate volunteers.

Action Steps	Organization Responsible	Timeline	Evaluation Measure
1.1 Identify and establish relationships with organizations that have existing pools of potential volunteers prior. • Identify key volunteer organizations to participate in plan development. • Develop a directory of volunteer organizations with contact information (primary, secondary, tertiary).	Primary: PHN/MRC facilitate conversation of Secondary: CERT, ARC, (Faith-based organization)	January – March 2013	List of volunteer organizations and contact information
1.2 Document existing policies and resources used for volunteer management by key volunteer organizations in the region. • Develop and implement an assessment of volunteer organizations to identify and evaluate existing volunteer requirements and capabilities. • Engage volunteer organizations in discussion regarding organization's interest in collaboration during a regional response. • Identify common volunteer requirements, capabilities that support response operations, and potential barriers or constraints to regional volunteer coordination.	Develop assessment – CHI Engage organizations and conduct assessment – PHN/MRC Analysis of information – CHI	February – June 2013	Assessment tool implemented and analyzed

1.3 Engage volunteer organizations to develop a regional volunteer coordination plan with standardized volunteer training and deployment guidelines. • Engage volunteer organizations to define volunteer training levels and to enhance volunteer skills that support response operations. • Establish minimum (e.g., IS 100 and IS 700) and advanced (e.g., MRC competencies) training requirements for deployment during an event. o Review federal requirements (FEMA and CDC Capability 3) for trainings. • Identify training opportunities across volunteer organizations and joint volunteer trainings. • Establish formal agreements with volunteer organizations (MOUs) that define roles and responsibilities for volunteer training and deployment.	PHN Coordinator/MRC Coordinator	July 2013 – June 2014	Meetings with volunteer organizations; MOUs establishing expectations for coordinated volunteer training and deployment
1.4 Enhance volunteer skills through shared trainings and exercises across participating volunteer organizations. • Identify training opportunities hosted by volunteer organizations, online, etc. • Develop and coordinate a calendar of regional training opportunities. Promote training by disseminating the calendar through participating volunteer organizations.	PHN Coordinator/MRC Coordinator		Training plan
1.5 Establish regular communications with participating volunteer organizations to facilitate regional coordination and collaboration • Maintain regular communications with participating volunteer organizations. • Establish protocols with participating volunteer organizations for volunteer notifications (e.g., standyby requests, activation, deployment, deactivation). o Explore using WebEOC (coordinate with mitigation strategy#2) to coordinate volunteers and volunteer needs during event ▪ In local event, get state to activate EOC so WebEOC can be used for volunteer management o Assess feasibility of using NH Responds to track and manage regional volunteers • Conduct post-event debriefings with volunteers and after-action assessment and improvement planning with participating volunteer organizations.	PHN/MRC Coordinator		Communications

1.6 Identify known non-statutory mechanisms to provide liability protection for volunteers. • Inventory liability protection available to volunteers within region • Work with the state and other regions to identify non-statutory mechanisms to provide liability protection for volunteers who cross over regions and cover non-MRC/CERT volunteers.	PHN Coordinator DHHS/HSEM		Liability protections understood for volunteer organizations
1.7 Drill activation, pending available funding.	PHN & partner organizations		Exercise; SNS Volunteer Call Down reports
1.8 Present state with recommendations for regional/statewide facilitation of volunteer management.	PHN Healthcare Coalitions/Regional Partners HSEM/DHHS CHI		Recommendations presented to state

Strategy 2: Standardize use of Web EOC for response communications.

Desired outcome: Increasing % of response partners login to WebEOC during incidents and exercises; increased, effective use of WebEOC as evidenced by AAR/IPs

Action Steps	Organization Responsible	Timeline	Evaluation Measure
2.1 Train response partners • Identify potential EOC/MACE staff who is trained and staff that needs training o Make request to response partners o Provide list of likely candidates	PHN Coordinator	By March 31, 2013	List of municipal and response partner staff who have WebEOC training and need WebEOC training.
• Increase WebEOC training opportunities o Request local training on a regular basis	PHN Coordinator and RCC members, HSEM Field	Request made by March 30, 2013; First local training held by	Training held; Increased number of individuals in region trained in WebEOC.

	Representatives	June 30, 2013	
• Request state hold webinars or develop online training coupled with an interactive training component	PHN Coordinator and RCC members, HSEM Field Representatives	Request made by March 30, 2013; Training available TBD	Request made. Online training program or webinar available.
• Identify grant funding (EMPG?, others?) for training to cover backfill and training time. • Apply for funding for to support training	PHN Coordinator and RCC members, HSEM Field Representatives PHN Coordinator and RCC members	Funding opportunities identified within 30 days. Funding applications submitted TBD	Funding sources identified; funding secured; training supported.
• Provide retraining opportunities o Hold regional WebEOC drills with state agency participation and ask state to allow region to exercise and request state evaluation o Request that state require periodic logins to encourage use	PHN Coordinator and RCC members, HSEM Field Representatives	By April 30, 2014	Drill planned and implemented; % of regional partners and state agencies logging in to WebEOC for drill. Development and implementation of AAR/IP
2.2 Establish working group to address improving WebEOC functionality. • Draft letter to HSEM Director to request state to have a working group with regional and local representation to discuss Web EOC functionality issues including: o Development of a develop a process to allow local EM/MACE to request incident be created in Web EOC o Notification of Web EOC users via e-mail when an incident is posted ▪ Defining/clarifying user authorizations ▪ What can I post when I login? ▪ What can I see? ▪ When? (ie: can locals post when they have an incident that they think rises to the occasion/how	PHN Coordinator coordinates joint letter form regional response partners.	January 31, 2013	Letter sent. Representatives selected. Working group attendance.

can WebEOC become more a tool for local use? • Determine who will represent region • Attend working group.			

Centers for Disease Control and Prevention (CDC)
BP4 Medical Countermeasure (MCM) Operational Readiness Review (ORR) Guidance

Budget Period 4

July 1, 2015 – June 30, 2016

Table of Contents

Introduction

In July 2014, the Centers for Disease Control and Prevention (CDC) implemented a new method of reviewing state and local medical countermeasure operational readiness. The medical countermeasure (MCM) operational readiness review (ORR) replaces CDC's technical assistance review (TAR) planning tool, which CDC used successfully for nearly a decade to review medical countermeasure planning at the state and local levels. CDC developed the MCM ORR with input from national partner associations and representatives of 19 state and local Public Health Emergency Preparedness (PHEP) jurisdictions. The MCM ORR tool builds on the progress jurisdictions have made over the years in planning for distributing and dispensing medical countermeasures and is intended to identify areas for improved implementation. The purpose of this document is to provide an overview of the MCM ORR tool.

The review process is designed to better determine the ability of a jurisdiction to implement plans in response to an incident or exercise requiring distribution and dispensing of medical countermeasures. The scope of the tool is expanded to align with the following eight public health preparedness capabilities:

- Capability 1: Community Preparedness
- Capability 3: Emergency Operations Coordination
- Capability 4: Emergency Public Information and Warning
- Capability 6: Information Sharing
- Capability 8: Medical Countermeasure Dispensing
- Capability 9: Medical Material Management and Distribution
- Capability 14: Responder Safety and Health
- Capability 15: Volunteer Management

With this process, awardees can expect a standardized approach to promote a more consistent and equitable evaluation of the response capacity within a jurisdiction. In addition, this process directs more attention to the operational implementation associated with planning elements within each capability.

State and Local Tool Application

CDC designed a comprehensive ORR tool for all 62 Public Health Emergency Preparedness (PHEP) cooperative agreement awardees, as well as Cities Readiness Initiative (CRI) local planning jurisdictions. The majority of the elements in the tool should be interpreted and applied at both

jurisdictional levels. Specific responsibilities may vary, and it is imperative that participants review each element carefully to determine relevance. For example, there are elements included in Capability 9 that apply at both the local and state levels.

If local jurisdictions are responsible for a particular function, the state must demonstrate that it provides guidance and assistance to local counterparts, in addition to monitoring, tracking, and evaluating local activities. States should document procedures for monitoring local operational activities for operational elements that truly do not apply to a state. For example, in Capability 8, while primary operational responsibilities pertain to local jurisdictions, the state has a direct role in providing guidance and training, as well as monitoring and evaluating various elements.

Determining Operational Readiness: Four Levels of Implementation

The MCM ORR does not use numerical scoring. Instead, it indicates jurisdictions' readiness status for each element using a continuum of implementation levels: early, intermediate, established, and advanced. The descriptions for these levels reflect enhancements based upon evaluation of Budget Period 3 (BP3) data and jurisdictional feedback. CDC expects that jurisdictions who demonstrate an advanced level of implementation will conduct continuous quality improvement activities within their own jurisdiction (e.g., development of an AAR/IP/CAP) and coordinate efforts with all key partners (i.e., federal, state, local, and community partners), particularly within CRI MSAs. CDC also expects that, over time, jurisdictions will demonstrate progress in implementing their response plans. CDC understands that factors may limit the ability to achieve an advanced level; however, jurisdictions should use continuous quality improvement processes to consistently identify gaps that lead to the improvement of planning and operations.

- **Early Implementation** - Jurisdiction demonstrates *some* of the planning and / or operational criteria.
- **Intermediate Implementation** - Jurisdiction demonstrates *many* of the planning and / or operational criteria.
- **Established Implementation** - Jurisdiction demonstrates *most* of the planning and / or operational criteria.
- **Advanced Implementation** - Jurisdiction demonstrates *all* planning and *all* operational criteria.

For each element in the MCM ORR, the four-implementation levels are defined by specific criteria. For example, under Planning Implementation, Capability 1: Community Preparedness, Function 2, element a. reads:

		Planning Implementation			
		Early	**Intermediate**	**Established**	**Advanced**
Function 2	Build community partnerships to support health preparedness	**a. Plans address partner engagement and document written acknowledgment of response roles for the following partners: 1) private sector, 2) local, 3) state, and 4) regional.**			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above

Demonstrating Operational Readiness

As it relates to medical countermeasures, CDC defines operational readiness as the capability of a jurisdiction to execute their medical countermeasure distribution and dispensing plans during a public health response. Operational readiness is demonstrated by conducting trainings and exercises or responding to incidents according to Homeland Security Exercise and Evaluation Program (HSEEP) guidance. HSEEP is based on national best practices and was developed to support the National Preparedness System. It provides a consistent approach to exercises and measuring progress toward building, sustaining, and delivering core capabilities. Jurisdictions **must** document results of the MCM distribution and dispensing full-scale exercise (FSE) according to HSEEP standards and principles.

Overlap with Performance Measures

CDC has taken into account overlapping PHEP performance measures and other exercise metrics in developing the MCM ORR. CDC does not intend to ask jurisdictions to duplicate efforts but rather to highlight important MCM and general incident planning and operational concepts. To assist jurisdictions in completing the MCM ORR, elements where there are direct synergies with PHEP performance measures are indicated throughout this document. When possible, jurisdictions are strongly encouraged to use program activities to meet these multiple requirements. The MCM ORR tool, and this guidance document, provides all necessary details to complete the review.

Documentation

While the focus of this operational assessment is on readiness to respond to an incident, there are situations where processes outlined in other plans or tested during a non-MCM incident or exercise could be used to meet certain elements of the ORR. Plans will be accepted as evidence to address certain elements of the tool as long as they include the criteria outlined in the tool and can be associated with MCM-specific operational

plans. Evidence from an incident or exercise can also be provided to address certain elements of the tool, regardless of the scenario, as long as the processes, procedures, and personnel used strongly translate to activities that would be expected during an incident or exercise involving MCM. This guidance provides example documentation for each element. Not all of the examples listed are required and some jurisdictions may have documentation that is not listed in the examples. Project officers in CDC's Division of State and Local Readiness (DSLR) have ultimate discretion in determination of acceptable documentation. Unless otherwise specified, supporting documentation for planning elements (including relevant training records) should be up-to-date, (no older than the date of the previous review). Documentation for operational elements will be accepted if the date of the exercise or incident falls within the timeframe indicated in the specific element.

Implementation

The state, local, tribal, and territorial (SLTT) authorities will use the MCM ORR tool to conduct their reviews. Budget Period 4 BP4 will be considered a baseline period in which CDC will collect data that is representative of MCM ORRs on a national scale. The MCM ORR data for PHEP awardees and CRI local planning jurisdictions will be publicly released.

CDC Implementation:

- CDC will conduct the MCM ORR for all 62 PHEP awardees
- CDC will conduct an MCM ORR for one CRI local planning jurisdiction within each CRI metropolitan statistical area (MSA)
    - For states with CRI MSAs that cross state borders, CDC will review a local planning jurisdiction from the state with the largest population within the MSA.
    - CDC may choose to review additional CRI local planning jurisdictions based on risk, operational gaps, or other criteria.

Awardee Implementation:

- Awardees are required to conduct operational reviews for all remaining CRI local planning jurisdictions and must submit the resulting data to CDC
- Awardees are expected to provide training on the MCM ORR tool and process to all local CRI planning jurisdictions
- Awardees may choose how they conduct reviews (i.e. video-teleconferences, webinars, conference calls, or a combination of all).

Submission

State and local CRI jurisdictions should complete a self-review and provide DSLR project officers with all supporting documentation for the MCM ORR at least **10 business days prior to the site visit**. Jurisdictions should use the forms located on the CDC MCM ORR SharePoint Site to conduct

the self-review. Documents must be submitted in final form; documents in draft form will not be accepted. All 62 PHEP awardees and all CRI local planning jurisdictions must submit MCM ORRs and jurisdictional data sheets (JDSs) by **May 1, 2016**.

MCM ORR Tool

Capability 1: Community Preparedness

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Determine risks to the health of the jurisdiction	**a. MCM planning elements include the following based on risk assessments: 1) definition of risk, 2) mapped locations of at-risk populations, 3) evidence of community involvement, 4) assessment of loss or disruption of essential services (i.e. water, sanitation, healthcare services, and public health agency infrastructure).**				**None**			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above				
Function 2	Build community partnerships to support health preparedness	**a. Plans address partner engagement and document written acknowledgment of response roles for the following partners: 1) private sector, 2) local, 3) state, and 4) regional.**				**a. Jurisdiction can provide evidence of how the roles and responsibilities of these partners have been used within the last five years.**			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise or real incident
Function 3	Engage with community organizations to foster public health, medical, and mental/behavioral health social networks	**a. Plan addresses engagement with community partners, to include medical and mental/behavioral health agencies to promote an understanding of and connection to MCM activities.**				**None**			
		No engagement procedure in plan	Engagement procedure for some but not all partners is outlined in the plan	Engagement procedure for all partners is outlined in the plan	Engagement procedure for all partners is outlined in the plan, which also includes a process for an information exchange between partners				

Capability 1: Community Preparedness

Function 4	Coordinate training or guidance to address community engagement in preparedness efforts	**a. Provide MCM-related public health preparedness and response training or guidance to community partners, including groups representing at-risk populations, to assist them in educating their own constituency groups regarding emergency preparedness and response plans.**				**None**			
		No training or guidance has been provided to community partners	Training or guidance has been provided to less than 50% of partners	Training or guidance has been provided to 50% or more but less than 100% of partners	Training or guidance has been provided to 100% of all community partners				

Capability 3: Emergency Operations Coordination

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Conduct preliminary assessment to determine need for public activation	**a. Plans describe strategies to coordinate with appropriate epidemiology, laboratory, medical, chemical, biological, and radiological subject matter experts (SMEs) to inform MCM decision-making. Plans should include the following elements: 1) analyze data, 2) assess emergency conditions, and 3) determine the activation levels based on the complexity of the event or incident required to support an MCM response.**				**a. Participation of appropriate subject matter experts to inform MCM decision-making has been exercised within the last five years.**			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements	Contact lists for all SMEs are on file	Necessary SMEs included in a tabletop exercise	Necessary SMEs included in a functional exercise	Necessary SMEs included in a full-scale exercise or a real incident
		b. Plans document a process depicting what/when actions would be initiated for 1) pre-event indicators, 2) notifications, 3) activations, 4) logistics, 5) operations, 6) sustained operations, or 7) demobilization.				**None**			
		Written plans contain none of the above elements	Written plans contain one to three of the above elements	Written plans contain four to six of the above elements	Written plans contain all of the above elements.				
		c. Plans identify the redundant communication platforms that are in place to ensure communications remain available should primary communication systems become unavailable				**c. Quarterly testing of redundant communications platforms is conducted and documented.**			
		Jurisdiction documents use of one or fewer communication platforms	Jurisdiction documents use of two communication platforms	Jurisdiction documents use of three communication platforms	Jurisdiction documents use of four or more communication platforms	Zero or one communication platform tested quarterly	Two communication platforms tested quarterly	Three communication platforms tested quarterly	Four or more communication platforms tested quarterly

Capability 3: Emergency Operations Coordination

Function 2	Activate public health emergency operations	**a. Plans identify staff with the subject matter expertise to fulfill required incident command and emergency management roles in emergency operations centers (EOCs) as required during an MCM response.**				**a. Incident command and emergency management staff have exercised required EOC roles during an MCM incident during the last five years.**			
		0-24% of staff identified	25-49% of staff identified	50-74% of staff identified	75-100% of staff identified	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		b. Plans 1) identify sites or virtual structure to serve as the unified health command (Health EOC), and 2) document procedures for setting up the Health EOC.				**b. Site activation (via staff assembly) of Health EOC or virtual structure supporting unified health command during an MCM incident at least every two years. NOTE: For awardees, this element refers to PHEP Performance Measure 3.1**			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain both of the above elements	Written plans contain both of the above elements and evidence that required parties have been trained	EOC not activated	EOC activated in more than 60 minutes	EOC activated in more than 45 and less than or equal to 60 minutes	EOC activated in 45 minutes or less
Function 3	Develop incident response strategy	**a. Plans document processes for completing the following elements required to support an MCM response: 1) incident action plan, 2) situation reports, and 3) finance/administration logs.**				**None**			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements				
Function 4	Manage and sustain the public health response	**a. Plans address continuity strategies in the event that primary systems are unavailable during an MCM response, including: 1) activation triggers, 2) loss of facilities (RSS, RDS, PODs, etc.), 3) loss of personnel, 4) orders of succession, and 5) devolution.**				**a. Continuity plans, as they apply to an MCM response, have been exercised within the last five years.**			
		Written plans contain none of the above	Written plans contain one or two of the above	Written plans contain three or four of the above	Written plans contain all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 3: Emergency Operations Coordination

Function 5	Demobilize and evaluate public health emergency operations	**a. Plans describe strategies to demobilize assets and personnel during an MCM incident. This includes the following elements: 1) development of processes with support agencies for collection and transport of assets and personnel, and 2) signed written agreements to support demobilization.**				**None**			
		No written plans in place	Written plans contain one of the above elements	Written plans contain all of the above elements	Written plans contain all of the above elements and demonstrate that required parties have been trained				
		b. Plans identify a sufficient number of staff (as defined by the jurisdiction) are trained in the Homeland Security Exercise and Evaluation Program (HSEEP) to develop after-action reports (AAR) and improvement plans (IP).				**None**			
		Written plans do not identify exercise/ training staff	Written plans identify exercise/training staff, but staffing gaps exist	Written plans identify exercise/ training staff, and no staffing gaps exist	Written plans identify exercise/ training staff, no staffing gaps exist, and jurisdiction employs at least one certified master exercise practitioner (MEP)				
		c. Plans identify processes and responsibilities for 1) developing a multi-year training and exercise plan (MYTEP), 2) conducting a hot wash, and 3) implementing IPs that incorporate MCM activities.				**c. Annual training and exercise plan (TEP) workshop is conducted and a MYTEP is produced that incorporates MCM, and completion of required documentation demonstrating that the IP has been implemented and exercise components have been retested and re-evaluated accordingly.**			
		No written plans in place	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements	TEP workshop not conducted	TEP workshop conducted but MYTEP not complete	TEP workshop conducted and MYTEP complete	TEP workshop conducted and MYTEP complete and demonstrates that IP has been developed and retested/ re-evaluated

Capability 4: Emergency Public Information and Warning

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Activate the emergency public information system	**a. Plans document public information and communication primary and back-up personnel who are trained in MCM responsibilities and current contact lists exist for these individuals.**				**None**			
		Plans do not identify public information and communication staff	Plans identify primary public information and communication staff	Plans identify primary and back-up public information and communication staff	Plans identify primary and back-up public information and communication staff and demonstrate that required parties have been trained				
Function 2	Determine the need for a joint public information system	**a. Plans include processes for the establishment of scalable joint information operations with MCM components, including 1) trigger points, and 2) decision criteria.**				**a. Joint information operations (scaled to the public information demands) have been exercised within the last five years.**			
		Written plans include none of the above elements	Written plans include one of the above elements	Written plans include all of the above elements	Written plans include all of the above elements and evidence that relevant parties have been trained	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 3	Establish and participate in information system operations	**a. Plans include procedures for 1) media notification (including an updated contact list) and credentialing, 2) press advisories and briefings, and 3) media monitoring and validation (including social media).**				**None**			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements				

Capability 4: Emergency Public Information and Warning

		b. Public health public information officer (PIO) responsibilities are documented in the job aid for the PIO or other MCM-designated staff and include the following elements: 1) coordinating information with the lead PIO and/or joint information center (JIC), 2) serving as the point-of-contact for the media, and 3) controlling public information messages and materials.				**None**			
		Written job aid not in place or job aid contains none of the above elements	Written job aid contains one of the above elements	Written job aid contains two of the above elements	Written job aid contains all of the above elements				
Function 4	Establish avenues for public interaction and information exchange	**a. Plans include methods for the public to contact the health department with MCM-related questions and concerns through 1) phone (i.e., call centers and/or help desks), 2) social media, 3) web chat, 4) e-mail, or 5) other communication platforms.**				**a. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years that demonstrates all applicable methods (referenced in the planning element) to address MCM-related questions/concerns from the public.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain three or more of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 5	Issue public information alerts, warnings, and notifications	**a. Plans include procedures for 1) information verification; 2) message development, approval, and clearance; and 3) message dissemination to the public, as they relate to an MCM mission.**				**a. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years in which public messages that incorporate MCM elements are created and disseminated.**			
		Written plans contain none of the above elements	Written plans contain one of the above elements	Written plans contain two of the above elements	Written plans contain all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		b. Plans include a process for the pre-incident and real-time translation of information specific to an MCM response to address the following populations of the jurisdiction: 1) non-English speaking, 2) hearing impaired, 3) visually impaired, and 4) limited language proficiency populations.				**b. The jurisdiction can provide evidence of participation in an exercise or real incident within the last five years where MCM materials were translated or adapted for applicable at-risk populations.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain three or more of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 6: Information Sharing

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Identify stakeholders to be incorporated into information flow	**a. Plans include procedures that 1) identify all stakeholders who would be involved in an MCM incident (including public health, medical, law enforcement and other disciplines), 2) outline communications pathways between and among these stakeholders, and 3) show evidence that current contact lists exist that include multiple contact mechanisms/devices for identified stakeholders.**				**a. Percentage of local partners that reported requested essential elements of information (EEI) to the public health/medical lead within the required timeframe (awardee defined) during an MCM incident within the last two years. NOTE: This element refers to HPP-PHEP Performance Measure 6.1. This element does not apply to local jurisdictions.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	0-24% report within timeframe	25-49% report within timeframe	50-74% report within timeframe	75-100% report within timeframe
Function 2	Identify and develop rules and data elements for sharing	**a. Plans document minimum requirements for information sharing during an MCM incident, including 1) when information should be shared, 2) who is authorized to receive and/or share information, 3) what types of information can be shared, 4) information use and re-release parameters, and 5) protection of information (including legal considerations).**				**None**			
		Written plans contain none of the above	Written plans contain one or two of the above	Written plans contain three or four of the above	Written plans contain all of the above				
Function 3	Exchange information to determine a common operating picture	**a. Plans include 1) procedures for sharing MCM-related information to enable a common operating picture, and 2) evidence of access to a platform to share this information,**				**a. Procedures (as referenced in the planning element) for sharing MCM-related information have been exercised within the last five years.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain all of above	Written plans contain all of the above and evidence that required parties have been trained	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 8: Medical Countermeasure Dispensing

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Identify and initiate medical counter-measure dispensing	**a. Guidance/plans document dispensing strategies (according to a tiered priority or alternate modality) to include: 1) open (public) PODs, 2) Closed PODs, and 3) Populations with Access and Function Needs.**				**a. Tiered priority or alternate dispensing modalities (as referenced in the planning element) have been exercised within the last five years.**			
		Written plans include none of the above	Written plans include one of the above	Written plans include two of the above	Written plans include all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		b. Guidance/plans document the capability to 1) initiate a dispensing campaign (i.e., initial 10-day prophylaxis regimen for anthrax) and 2) sustain dispensing campaign follow-on needs (i.e., additional 50-day regimen of prophylaxis for anthrax).				**b. The capability to initiate a dispensing campaign and transition to sustained dispensing operations has been tested within the last five years.**			
		No written plans in place	Written plans include procedures to initiate operations	Written plans include procedures to initiate and procedures to sustain operations are in development	Written plans include completed procedures to initiate and sustain operations for 100% of the jurisdiction's population	No exercise conducted	Workshop, seminar or equivalent activity has been conducted	Tabletop exercise conducted	Functional, full-scale exercise conducted or real incident
		c. Guidance/plans identify healthcare partners that would participate in MCM activities and include: 1) list of current healthcare partners with appropriate contact information, 2) MOUs (or other signed written agreements) with these organizations, 3) procedures for how these healthcare partners will participate in MCM activities (including asset request procedures), and 4) planning guidance for those partners participating as closed PODs.				**c. Jurisdiction has participated in exercises (tabletop, functional or full-scale) or real incidents with healthcare partners related to closed PODs, MCM asset request procedures, or other MCM activities within the last five years.**			
		Written plans include none of the above elements	Written plans include one to three of the above elements	Written plans include all of the above elements	Written plans include all of the above elements and evidence that required parties have been trained	Participation with 0-24% of identified healthcare partners	Participation with 25-49% of identified healthcare partners	Participation with 50-74% of identified healthcare partners	Participation with 75-100% of identified healthcare partners

Capability 8: Medical Countermeasure Dispensing									
Function 2	Receive medical counter-measures at POD	**a. Guidance/plans for open (public) PODs include dispensing site surveys that document: 1) required equipment and resources, 2) procedures to acquire these resources, 3) current contact lists for site/facility, and 4) Memorandums of Understanding (MOUs) (or other written agreements).**				**a. Dispensing site set-up has been tested (via drills, functional, or full-scale exercises or a real incident) within the last five years for all open (public) PODs within the planning jurisdiction.**			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above	0-24% of sites tested	25-49% of sites tested	50-74% of sites tested	75-100% of sites tested
Function 3	Activate dispensing modalities	**a. Guidance/plans for open (public) PODs identify all personnel required to staff dispensing sites, in accordance with planning estimates, and contact lists for these individuals are current.**				**a. Quarterly call down drills conducted among pre-assigned core staff needed to staff dispensing sites.**			
		0-24% of personnel identified	25-49% of personnel identified	50-100% of personnel identified	75-100% of personnel identified *and* pre-assigned according to operational position and geographical assignment	Call down conducted less than quarterly or percent acknowledgement between 0-24%	Call down conducted quarterly and percent acknowledgement between 25-49%	Call down conducted quarterly and percent acknowledgement between 50-74%	Call down conducted quarterly and percent acknowledgement between 75-100%

Capability 8: Medical Countermeasure Dispensing									
Function 4	Dispense medical countermeasures to identified population	**a. Guidance/plans address and document operational planning elements necessary to provide MCM to the public at open (public) PODs, including: 1) dispensing flow, 2) screening forms, 3) mechanisms and trigger points to increase throughput, and 4) assisting populations with access and functional needs.**				**a. Jurisdiction has tested (drill, functional, full scale exercise or real incident) all planning elements necessary to provide MCM to the public within the last five years and has calculated throughput capacity for each dispensing site.**			
		Written plans include none of the above	Written plans include one or two of the above	Written plans include three of the above	Written plans include all of the above	0-33% of sites tested	34-66% of sites tested	67-100% of sites tested, but necessary throughput levels not met	67-100% of sites tested, and necessary throughput levels met for all tested sites
		b. Guidance/plans for open (public) PODs include procedures for 1) operating a full medical POD, 2) operating a non-medical POD, and 3) transitioning from one to the other during an MCM incident.				**None**			
		Written plans include none of the above	Written plans include one of the above	Written plans include two of the above	Written plans include all of the above				
Function 5	Report adverse events	**a. Guidance/plans for open (public) PODs evidence that adverse event reporting procedures are included in: 1) dispensing site protocols, 2) job aides, and 3) information sheets provided to the public as they leave the site.**				**None**			
		Procedures are included in none of the above	Procedures are included in one of the above	Procedures are included in two of the above	Procedures are included in all of the above				

Capability 9: Medical Material Management and Distribution

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Direct and activate medical material management and distribution	**a. Plans identify receiving locations (receipt, stage and store (RSS) sites/regional distribution sites (RDS)/local distribution sites (LDS)) for medical countermeasures.**				**a. Receiving sites have been exercised (functional exercise, full scale exercise or real incident) according to distribution plans (RSS/RDS/LDS) within the last five years.**			
		0-24% of sites have completed and submitted current site survey	25-49% of sites have completed and submitted current site survey	50-74% of sites have completed and submitted current site survey	75-100% of sites have completed and submitted current site survey	0-24% of sites conducted exercises	25-49% of sites conducted exercise	50-74% of sites conducted exercises	75-100% of sites conducted exercises
		b. Plans identify primary and back-up transportation assets from public and/or private sources and include a transportation asset list.				**b. Transportation assets have been exercised according to distribution plans within the last five years.**			
		Necessary transportation assets and/or source of these assets is not identified or documented	Necessary transportation assets and source of these assets are identified and documented	Necessary primary and back-up transportation assets and source of these assets are identified and documented	Necessary primary and back-up transportation assets and source of these assets are identified and documented and an MOU (or similar agreement) is in place	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
		c. Plans identify all personnel needed to staff receiving sites (RSS/RDS/LDS).				**c. Quarterly call-down drills conducted among all personnel needed to staff receiving sites (RSS/RDS/LDS).**			
		No written plans in place or no personnel identified	Written plans identify primary personnel	Written plans identify primary and back-up personnel	Written plans identify primary and back-up personnel who have evidence of training *and* are pre-assigned according to operational position and geographical assignment	Call-down drill conducted less than quarterly or percent acknowledgement between 0-24%	Call-down drill conducted quarterly and percent acknowledgement between 25-49%	Call-down drill conducted quarterly and percent acknowledgement between 50-74%	Call-down drill conducted quarterly and percent acknowledgement between 75-100%

Capability 9: Medical Material Management and Distribution									
Function 2	Acquire medical material	**a. Plans include procedures to request medical material from 1) jurisdictional, 2) private, 3) regional, and/or 4) federal partners in alignment with National Incident Management System standards and incident needs.**				**a. Processes (as referenced in the planning element) for requesting medical material have been exercised within the last five years.**			
		No written plans in place or plans do not contain any of the above elements	Written plans contain one or two of the above elements	Written plans contain three of the above elements	Written plans contain all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise or real incident
		b. Plans include procedures to maintain integrity of medical material according to jurisdictional requirements and manufacturer specifications, including 1) cold chain management, 2) tracking by lot number, 3) tracking by expiration date, and 4) chain of custody (controlled and non-controlled substances).				**b. Procedures (as referenced in the planning element) to maintain integrity of medical material in accordance with jurisdictional requirements and manufacturer specifications have been exercised within the last five years.**			
		No written plans in place	Written plans include one or two of the above elements	Written plans include three of the above elements	Written plans include all of the above elements	No exercise conducted	Seminar, workshop, or equivalent activity conducted	Tabletop exercise conducted	Functional, full-scale exercise or real incident

Capability 9: Medical Material Management and Distribution									
Function 3	Maintain updated inventory management and reporting system	**a. Plans include procedures to operate a primary and back-up inventory management system (IMS) during an MCM incident.**				**a. Demonstrate the ability to receive, store, pick, and ship assets from both primary and backup system.**			
		Written plans do not include procedures to operate a primary or backup IMS	Written plans include procedures to operate a primary IMS but not a backup	Written plans include procedures to operate a primary and backup IMS	Written plans include procedures to operate a primary and backup IMS and evidence that pre-identified warehouse staff have been trained on IMS functions	Unable to demonstrate ability	Only the primary IMS has demonstrated the ability to receive, store, pick, and ship assets	Both primary and backup IMS demonstrated the ability to receive, store, pick and ship assets	Both primary and backup IMS demonstrated the ability to receive, store, pick, and ship assets and documentation staff have been trained
		b. Plans outline processes to track and report inventory levels from all entities within a jurisdiction.				**b. Procedures to track and report inventory levels have been exercised within the last five years.**			
		No plan is in place to collect inventory levels	A plan is in place but unable to collect inventory levels from any entity within the jurisdiction	A plan is in place to collect inventory levels from at least 50% of all entities within a jurisdiction	A plan is in place to collect inventory levels from all entities within a jurisdiction and appropriate staff are trained on collection procedures	Unable to collect and report all inventory levels	All inventory levels can be collected but not reported	All inventory levels can be collected and structure for reporting is in development	All inventory levels can be collected and inventory records can be reported successfully*

Capability 9: Medical Material Management and Distribution									
Function 4	Establish and maintain security	**a. Plans include procedures to identify, acquire, and maintain security measures at all MCM distribution sites (RSS/RDS/LDS).**				**a. Security plans for receiving site (RSS, RDS, LDS) have been exercised (tabletop, functional, or full-scale exercise or real incidents) within the last five years.**			
		0-24% of all sites have security plans	25-49% of all sites have security plans	50-74% of all sites have security plans	75-100% of all sites have security plans	0-24% of security plans have been exercised	25-49% of security plans have been exercised	50-74% of security plans have been exercised	75-100% of security plans have been exercised
		b. Plans include procedures to identify, acquire, and maintain security measures at all public MCM dispensing sites (general points of dispensing [PODs]).				**b. Security plans for public dispensing sites (general PODs) have been exercised (tabletop, functional, or full-scale exercises or real incidents) within the last five years.**			
		0-24% of all PODs have security plans	25-49% of all PODs have security plans	50-74% of all PODs have security plans	75-100% of all PODs have security plans	0-24% of security plans have been exercised	25-49% of security plans have been exercised	50-74% of security plans have been exercised	75-100% of security plans have been exercised
		c. Plans include processes for the security of MCM assets through all applicable distribution phases up to and including arrival distribution end points and an MOU (or similar written agreement) is in place with security partners.				**c. Transportation security plans for the applicable phases referenced in the planning element have been exercised (tabletop, functional, full-scale exercises or real incidents) within the last five years.**			
		No written plans in place	Written plan in place but does not include an MOU (or similar agreement)	Written plans in place that include an MOU (or similar agreement)	Written plans in place that include an MOU (or similar document) and evidence that necessary security partners have been trained	0-24% of security plans have been exercised	25-49% of security plans have been exercised	50-74% of security plans have been exercised	75-100% of security plans have been exercised

Capability 9: Medical Material Management and Distribution									
Function 5	Distribute medical material	**a. Plans include procedures to determine allocation and distribution strategy, including 1) delivery locations, 2) routes, and 3) delivery schedule/frequency, based on incident needs.**				**a. Jurisdiction has demonstrated capacity to transport material from receiving sites (RSS/RDS/LDS) to identified dispensing sites according to planning assumptions (modeling, exercise, or real incident) within the last five years.**			
		No written plans in place	Written plans include one of the above elements	Written plans include two of the above elements	Written plans include all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 6	Recover medical material and demobilize distribution operations	**a. Plans include procedures to 1) recover material, 2) recover equipment, and 3) dispose of biomedical waste materials according to jurisdictional policies and protocols.**				**a. Recovery and waste disposal procedures have been exercised within the last five years.**			
		No written plans in place	Written plans include one of the above elements	Written plans include two of the above elements	Written plans include all of the above elements	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident

Capability 14: Responder Safety and Health

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Identify responder safety and health risks	**a. Plans include procedures for protecting public health staff and volunteer responders, to include 1) identifying and communicating medical and behavioral health risks, 2) validating health and safety recommendations with subject matter experts, and 3) identifying personal protective equipment (PPE), protective actions, or other mechanisms as they relate to an MCM mission.**				**a. All procedures (as referenced in the planning element) for protecting public health staff and volunteer responders have been exercised within the last five years.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No exercise conducted, or exercise did not address all procedures	Workshop, or equivalent, conducted	Tabletop exercise conducted	Functional or full-scale exercise conducted or real incident
		b. Plans: 1) identify all responders (including first responders and critical infrastructure staff (CIS)) that would be used in an MCM incident, 2) describe procedures for priority prophylaxis of identified responders (including first responders/CIS), and 3) describe resources necessary to conduct priority prophylaxis of responders (including first responders/CIS).				**b. Procedures for the prophylaxis of all responders (including first responders/CIS) have been exercised within the last five years.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise conducted or real incident
Function 2	Identify safety and personal protective needs	**a. Plans include procedures for 1) training on PPE, 2) PPE fit-testing, 3) medically clearing staff to use PPE, and 4) obtaining additional PPE appropriate for the MCM incident.**				**None**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two or three of the above	Written plans contain all of the above				

Capability 14: Responder Safety and Health

<table>
<tr><td rowspan="3">Function 3</td><td rowspan="3">Coordinate with partners to facilitate risk-specific safety and health training</td><td colspan="4">a. Plans document procedures for MCM just-in-time training for 1) first responders, 2) critical infrastructure staff, 3) volunteer responders, and 4) staff responders regarding their own safety and health.</td><td colspan="4" rowspan="2">None</td></tr>
<tr><td>Written plans include none of the above elements</td><td>Written plans include one or two of the above elements</td><td>Written plans include three of the above elements</td><td>Written plans include all of the above elements</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">Function 4</td><td rowspan="3">Monitor responder safety and health actions</td><td colspan="4">a. Plan includes procedures for 1) monitoring health and safety of all responders, 2) providing medical and behavioral health services to all responders, and 3) modifying health and safety recommendations based on available surveillance, as they relate to an MCM mission.</td><td colspan="4">a. Procedures for monitoring responder safety and health actions have been exercised within the last five years.</td></tr>
<tr><td>Written plans include none of the above</td><td>Written plans include one of the above</td><td>Written plans include two of the above</td><td>Written plans include all of the above</td><td>No exercise conducted</td><td>Tabletop exercise conducted</td><td>Functional exercise conducted</td><td>Full-scale exercise conducted or real incident</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Capability 15: Volunteer Management

		Planning Implementation				Operational Implementation			
		Early	**Intermediate**	**Established**	**Advanced**	**Early**	**Intermediate**	**Established**	**Advanced**
Function 1	Coordinate volunteers	**a. Plans include procedures for 1) pre-incident volunteer recruitment and identification, including a registration system, 2) pre-incident screening and credential verification, and 3) pre-incident training on public health response capabilities as they relate to an MCM mission.**				**a. Plans related to volunteer registration systems, pre-incident screening, credentials verification, and pre-incident training have been exercised within the last five years.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No exercise conducted	Tabletop exercise conducted	Functional exercise conducted	Full-scale exercise or real incident
Function 2	Notify volunteers	**a. Plans include procedures for 1) volunteer notification, with redundant systems and template messages, 2) partner agency notifications for staff support, and 3) credential confirmation at time of incident, as they relate to an MCM mission.**				**a. Jurisdiction conducts annual call-down drill of all volunteers required to support an MCM mission.**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above	No call- down drill, or percent acknowledgement between 0-24%	Call-down drill conducted and percent acknowledgement between 25-49%	Call-down drill conducted and percent acknowledgement between 50-74%	Call-down drill conducted and percent acknowledgement between 75-100%

Capability 15: Volunteer Management

Function 3	Organize, assemble, and dispatch volunteers	**a. Plans include procedures for 1) assembling and rotating volunteers, 2) providing volunteer support services (feeding, housing, etc.), and 3) briefing volunteers through job aids, just-in-time training materials, safety instructions, etc.**				**None**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above				
		b. Plans include a process for 1) badging volunteers, 2) managing spontaneous volunteers, and 3) coordinating with emergency management, or other jurisdictional lead, for support of public health volunteers				**None**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above				
Function 4	Demobilize volunteers	**a. Plans include procedures (manual or electronic system) for 1) tracking, 2) out-processing, and 3) providing follow-up services to volunteers.**				**None**			
		Written plans contain none of the above	Written plans contain one of the above	Written plans contain two of the above	Written plans contain all of the above				

Capability 1: Community Preparedness

Function 1**:** *Determine risks to the health of the jurisdiction*

a. Planning Implementation

Intent: To effectively implement a dispensing campaign, jurisdictions must consider numerous community factors. Each of these planning elements is a unique consideration that jurisdictions need to integrate in their MCM plans for an effective response. The intent of this element is to determine whether a jurisdiction's plans include formal risk assessments (such as jurisdictional risk assessments [JRAs] or hazard vulnerability analyses [HVAs] and identify the risks that can adversely affect its ability to mount an efficient dispensing campaign and incorporate mitigation strategies into the planning process., based on formal risk assessments (including JRAs/HVAs) Jurisdictions should have or have access to mapped locations of the identified at-risk populations.

This element accounts for all populations that could be considered vulnerable to the identified risk(s), not just those with access and functional needs. These include populations that may have additional needs in one or more of the following functional areas:

- Maintaining independence: individuals in need of support that enables them to be independent in daily activities
- Communication: individuals who have limitations that interfere with the receipt of and response to information
- Transportation: individuals who cannot drive due to the presence of a disability or who do not have a vehicle
- Supervision: individuals who require the support of caregivers, family, or friends or have limited ability to cope in a new environment
- Medical care: individuals who are not self-sufficient or do not have, or have lost, adequate support from caregivers and need assistance with managing medical conditions

In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) (i.e., children, senior citizens, and pregnant women) individuals who may need additional response assistance could include those who have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or do not speak English; are transportation disadvantaged; have chronic medical disorders; have pharmacological dependency; and are geographically isolated.

Example Documentation or Evidence: Acceptable evidence may include JRAs or HVAs, standard operating procedures, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1; Analysis of Risk Communication Strategies and Approaches with At-Risk Populations to Enhance Emergency Preparedness, Response, and Recovery: Final Report (2008); Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA) (2013); SNS State TAR User Guide Version 1.0 (2012), Element 1.4

Function 2: *Build community partnerships to support health preparedness*

a. Planning Implementation

Intent: An emergency incident will require the coordinated efforts of federal, state, local, and community partners to provide MCM quickly to those who need it. Jurisdictional plans must clearly identify the responsibilities of agencies and organizations with a role during MCM deployment. Plans for coordinated efforts should identify necessary partners and include designated roles and responsibilities for related emergency support function partners and other community partners who will play a role in the MCM response. These necessary partners should be identified by the jurisdiction.

Example Documentation or Evidence: Acceptable evidence includes documentation indicating that all agencies and organizations have acknowledged their roles and responsibilities in MCM planning elements. Examples of supporting documentation include signatory pages, letters of acknowledgment, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1

a. Operational Implementation

Intent: Demonstrated coordination of government and community partners ensures that these designated entities understand and can execute their roles. Exercise types are defined in accordance with Homeland Security Exercise and Evaluation Program (HSEEP) principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation

depending on the type of exercise or incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, corrective action plans (CAPs), IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years prior to the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

***Function 3**: Engage with community organizations to foster public health, medical and mental/behavioral health social networks*

a. Planning Implementation

Intent: An MCM incident and the subsequent dispensing campaign may have various adverse effects on staff and the general population, including health and/or mental health issues related to the stress of the incident. To help mitigate these concerns, jurisdictions should identify and engage jurisdiction-defined, relevant community partners prior to an incident.

Example Documentation or Evidence: Acceptable evidence may include written agreements, standard operating procedures, sign-in logs or training rosters, training and guidance materials, or other documents that indicate that public health interacts with these community partners.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1; National Biodefense Science Board "Integration of Mental and Behavioral Health in Federal Disaster Preparedness, Response, and Recovery: Assessment and Recommendations" (2010)

***Function 4**: Coordinate training or guidance to ensure community engagement in preparedness efforts*

a. Planning Implementation

Intent: For community partners to engage all necessary constituencies, they must have appropriate levels of understanding regarding the jurisdiction's planned response strategy for an MCM incident. While community partners may vary from jurisdiction to jurisdiction, it is important that a jurisdiction identifies relevant partners to represent all constituencies and provides guidance and training to these groups.

Example Documentation or Evidence: Acceptable evidence may include sign-in logs or training rosters and guidance materials.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 1; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 12.6; SNS State TAR User Guide Version 1.0 (2012), Element 13.6

Capability 3: Emergency Operations Coordination

Function 1: *Conduct preliminary assessment to determine need for public activation*

a. Planning Implementation

Intent: An emergency will require the efforts of various subject matter experts (SMEs) to inform the decision-making process regarding MCM resource needs. To maximize the amount of available time to provide prophylaxis and/or treatment to the population at risk, a jurisdiction should establish processes to inform necessary officials on decisions to request assistance during the early stages of a public health emergency. At a minimum, policies should define the coordination of the SME contributions related to these planning elements.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, official policies, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 3.2

a. Operational Implementation

Intent: Demonstrated coordination of SMEs ensures that these individuals understand and can execute their roles. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: To plan for an effective dispensing campaign, a jurisdiction must define specific actions necessary at various phases of the response. In its plans, the jurisdiction should identify each phase of the response and the associated actions that take place during each phase. A timeline is an optimal format to effectively illustrate required actions in each phase.

Example Documentation or Evidence: Acceptable evidence may include timelines, time flow models, algorithms, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

c. Planning Implementation

Intent: Because effective communication is critical to successful public health emergency responses, every method of communication between management and command locations and support agencies should have some form of back-up system. Jurisdictions should prioritize redundant communications that use multiple platforms (i.e., cellular technologies) and not multiple devices or methods of communication that operate on the same platform (i.e., cell phone calls and text messages).

Example Documentation or Evidence: Acceptable evidence includes documentation of any of the following systems:

- Landline dependent telecommunications; landline telephones, fax, dial-up/DSL Internet and e-mail
- Non-telephone based Internet, e-mail and Web-based communications access systems; satellite or cable
- Cellular technologies and communications; phone, text messages
- Amateur (HAM) radio
- Two-way VHF/UHF/700/800/900 MHz communications
- Satellite telephone communications

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 4.5

c. Operational Implementation

Intent: Routine testing of communication platforms helps ensure their operational readiness for an incident, as well as responder familiarity with these systems. Testing should be emphasized for systems that are not used daily.

Example Documentation or Evidence: Acceptable evidence may include call logs, computer-tracking mechanisms, AARs, drill summary sheets, memos for record, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 4.5

Function 2: *Activate public health emergency operations*

a. Planning Implementation

Intent: Incident Command System (ICS) is a fundamental form of management established in a standard format that enables incident managers to identify the key concerns associated with the incident. Managing the response to a public health emergency will require organizations to collaborate across a variety of incident management functions and emergency management roles. Integration of MCM functions enables effective incident management.

Example Documentation or Evidence: Acceptable evidence may include ICS charts (with specific individuals identified to fill specific roles) and evidence that the following functions have been integrated into the established ICS roles: staffing/volunteer coordination, tactical communications/IT support, security coordination, RSS operations, distribution operations, dispensing site operations, hospital/treatment center coordination, public information and communication, and safety coordination.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 2.2 and 2.5

a. Operational Implementation

Intent: Demonstrated use of ICS that incorporates these MCM functions within the emergency operations center (EOC) ensures that ICS staff members understand and can execute their roles as required during an MCM incident.

Example Documentation or Evidence: Acceptable evidence includes proof of master exercise practitioner (MEP) certification, AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: A predetermined physical or virtual location is necessary to coordinate unified health command activities and facilitate an effective response. Jurisdictions should define all required procedures for establishing a health EOC and train all responsible parties on those procedures.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, as well as written agreements, EOC activation plans, training logs, sign-in sheets, training materials, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

b. Operational Implementation[1]

Intent: To ensure a timely and effective response to an MCM incident, jurisdictions must demonstrate the ability to rapidly assemble public health staff with senior incident management lead roles. For awardees, this element is linked with PHEP performance measure 3.1 (Staff Assembly). There is a two-year timeframe to ensure consistency with this performance measure. Local jurisdictions can use exercises conducted in the context of the staff notification drill as long as they choose to include the EOC staff.

Example Documentation or Evidence: Data from performance measure PHEP 3.1 will be used to populate this element for awardees. CRI planning jurisdictions should provide evidence supporting site activation, including drill summary sheets, sign-in logs, AARs, etc., of the EOC to the reviewer.

Reference(s): PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014) – Staff Notification Drill: Capability 3, PHEP 3.1; PHEP Medical Countermeasure Reference Guide

Function 3: *Develop incident response strategy*

a. Planning Implementation

[1] Data from performance measure PHEP 3.1 will be used to populate this element for awardees. CRI planning jurisdictions should provide evidence, as described below.

Intent: Effective coordination of an MCM incident will require adherance to ICS principles, including processes and procedures for the completion of these planning elements. Successful responses depend upon having written jurisdictional processes and procedures for an MCM incident, including identification of the parties responsible for completing them.

Example Documentation or Evidence: Acceptable evidence may include MCM-specific templates, standard operating procedures, job aids, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3; FEMA, ICS (http://www.fema.gov/incident-command-system)

Function 4: *Manage and sustain the public health response*

a. Planning Implementation

Intent: During an MCM incident, it is critical for a jurisdiction to maintain pre-identified essential public health services, including the functions necessary to conduct the dispensing campaign, in the absence of primary operational readiness. Training on these procedures is paramount to ensure viable continuity of operations.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, continuity of operations plans (COOP), training logs, sign-in sheets, training materials, etc.

Reference(s): Federal Emergency Management Agency (FEMA), Continuity of Operations (http://www.fema.gov/continuity-operations/continuity-operations-capabilities); *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

a. Operational Implementation

Intent: Due to the complexity of implementing a viable continuity strategy, jurisdictions should test their plans and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation

depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence may include AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 5: *Demobilize and evaluate public health emergency operations*

a. Planning Implementation

Intent: It is important that a jurisdiction maintains processes for scaling down the response campaign during (i.e., a reduction in the number of operational points of dispensing [PODs]) and at the conclusion of an MCM incident. Jurisdictions should pre-identify necessary resources according to these planning elements to efficiently restore systems, supplies, and staffing to their normal state of operations.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, inventory logs, chain of custody forms, disposition logs, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 3

b. Planning Implementation

Intent: To plan for MCM-related training and exercises, a jurisdiction should maintain dedicated staff to develop training and exercise programs according to HSEEP guidance (including the development of AARs and IPs). Jurisdictions at an advanced level of implementation should have access to and routinely use a MEP to plan MCM-related training and exercises.

Example Documentation or Evidence: Acceptable evidence may include personnel staffing lists, training certificates, job aids, etc.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

c. Planning Implementation

Intent: Planning exercises can be time-consuming and expensive; therefore, it is vital to take a long-term approach to exercising. Advance planning provides opportunities to consolidate exercises, thus relieving the burden. MCM activities should be included when developing a multi-year training and exercise plan (MYTEP) and considered in continuous quality improvement activities.

Example Documentation or Evidence: Acceptable evidence may include MYTEPs, AARs, IPs, hot wash documents, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); SNS State TAR User Guide Version 1.0 (2012), Element 13.3 and 13.4

c. Operational Implementation

Intent: A jurisdiction should conduct an annual training and exercise plan workshop to provide direction for developing its training and exercise plans and increase visibility of participating organizations training and exercise plans. Though exercise planning is a continuous process, updates to the multi-year training and exercise plan (MYTEP) and related IPs must occur at least annually. An advanced level of operational implementation indicates that the jurisdiction has retested and re-evaluated the gaps identified in IPs.

Example Documentation or Evidence: Acceptable evidence may include agendas, meeting minutes, sign-in sheets, IPs, AARs, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); SNS State TAR User Guide Version 1.0 (2012), Element 13.3 and 13.4

Capability 4: Emergency Public Information and Warning

Function 1: *Activate the emergency public information system*

a. Planning Implementation

Intent: Public information and communication (PIC) personnel regularly inform, educate, and communicate with the public. When planning to respond to an incident that requires mobilizing the public to perform specific actions, it is critical that PIC personnel understand and are involved in the response to provide information that empowers the public to make the right choices for their health. For all identified staff, jurisdictions should maintain and make accessible contact information that is updated quarterly.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communication plans, contact lists, training logs, sign-in sheets, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 5.1

Function 2: *Determine the need for a joint public information system*

a. Planning Implementation

Intent: Depending on the nature of the incident, public information demands may vary. Jurisdictions should have processes in place to establish a scalable joint information center, and plans should include trigger points and decision criteria. A decision matrix will help inform what resources, including personnel resources (such as MCM SMEs) and equipment, may be needed to coordinate the dissemination of information.

Example Documentation or Evidence: Acceptable evidence may include decision matrices, algorithms, standard operating procedures, communication plans, equipment lists, contact lists, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 4

a. Operational Implementation

Intent: Jurisdictions should test their ability to scale the dissemination of public information to the specific demands of an MCM incident. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 3: *Establish and participate in information system operations*

a. Planning Implementation

Intent: Jurisdictions should identify methods and mechanisms of communication with media contacts before an incident occurs to ensure media partners are identified and involved in the public information dissemination process. It is also important for jurisdictions to ensure that messages are being accurately and effectively conveyed to the public.

Example Documentation or Evidence: Acceptable evidence may include contact lists, standard operating procedures, communications plans, template for press briefings, job aids, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 4; SNS Local TAR User Guide (2010), Element 5.3; SNS State TAR User Guide Version 1.0 (2012), Element 5.4

b. Planning Implementation

Intent: In an MCM incident, trained, knowledgeable personnel are invaluable to communications functions such as interfacing with the media and providing public information at dispensing sites. Job aids should include key PIC responsibilities, as outlined in the planning elements.

Example Documentation or Evidence: Acceptable evidence may include job aids, standard operating procedures, communications plans, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 5.3

Function 4: *Establish avenues for public interaction and information exchange*

a. Planning Implementation

Intent: Jurisdictions should ensure that mechanisms exist for the public to contact the health department with MCM-related questions and concerns and for the health department to disseminate messages to the public. It is important that communications plans include a variety of mechanisms by which the public can contact the health department, as outlined in the planning elements, and that the public is informed of these mechanisms.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communications plans, public information announcements, documentation of hotline numbers, e-mail addresses, social media accounts, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 4 (page 41)

a. Operational Implementation

Intent: Jurisdictions should test their procedures for responding to inquiries from the public and demonstrate operational readiness in this area. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 5: *Issue public information alerts, warnings, and notifications*

a. Planning Implementation

Intent: Developing and clearing messages prior to an MCM incident and planning for their dissemination can reduce the timeline required to get the first messages out to all targeted audiences. Well-crafted, accurate, and consistent messages are important during an emergency to help gain trust and encourage the public to make the right choices regarding their health. These key messages are the basis for all communication materials used before, during, and after an incident.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communications plans, and pre-developed fact sheet templates, media kits, press release templates, flyers, brochures, videos, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 5.6; SNS State TAR User Guide Version 1.0 (2012), Element 5.5

a. Operational Implementation

Intent: Jurisdictions should test their plans for message creation and dissemination and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Plans to provide information to the population should address segments of the population that may need targeted messages, materials, and/or alternate methods of delivering those messages and materials. Examples of these segments of the population include those with language or literacy barriers. The intent of this element is to help to ensure that those segments of the population are not overlooked and receive the information they need in the manner most useful to them.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, communications plans, and pre-developed fact sheets, media kits, press news releases or template releases, flyers, brochures, videos, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 5.7; SNS State TAR User Guide Version 1.0 (2012), Element 5.6

b. Operational Implementation

Intent: Jurisdictions should test message translation capabilities for identified at-risk populations listed in the planning element and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Capability 6: Information Sharing

Function 1: *Identify stakeholders to be incorporated into information flow*

a. Planning Implementation

Intent: Response to a public health emergency requires the support and collective effort of many diverse agencies. Appropriate planning entails coordination, collaboration, and integration between those agencies to ensure a multi-disciplinary approach. Prior to an incident, it is essential for each entity or location involved in the response to know the agency(ies), and the position(s) within those agencies, with whom they must communicate for guidance, requests, and information and identify the communication pathways (or lines of communication) necessary for this information exchange. The intent for this element is to engage the agencies that have the responsibility or authority for the functions that are relevant to the MCM plan. Contact lists should be updated annually.

Example Documentation or Evidence: Acceptable evidence for stakeholder identification includes staff contact lists (updated annually) with multiple contact devices/mechanisms listed (i.e., cell phone, e-mail, etc.), human resources or volunteer database reports, other tracking systems, etc. Acceptable evidence for communication pathways may include flow charts, matrices, graphs, maps using graphic information systems (GIS), lists/paragraphs within the plan, or a completed ICS-205 form.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 1.3; SNS State TAR User Guide Version 1.0 (2012), Element 4.3

a. Operational Implementation[2]

Intent: The intent of this measure is to determine the extent to which local response entities communicate requested information to the public health/medical lead to facilitate situational awareness and the effective, timely management of resources during an MCM incident. Essential elements of information that may be necessary during an MCM incident include identification of all stakeholders, communication pathway matrix, current contact lists, and the percentage of partners that reported essential elements of information (EEI) during an exercise or incident.

[2] *Data from performance measure HPP-PHEP 6.1 will be used to populate this element for awardees. This measure only applies at the awardee level.*

Example Documentation or Evidence: See PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 6, HPP-PHEP 6.1.

Reference(s): PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 6, HPP-PHEP 6.1

Function 2: *Identify and develop rules and data elements for sharing*

a. Planning Implementation

Intent: Defining clear data sharing parameters helps to ensure appropriate and secure information-sharing practices during an incident. Plans should include procedures related to what information can be shared, when it can be shared, and who it can be shared with, from both operational and legal standpoints. For example, sensitive information about POD operating hours, locations, or operational challenges may only be shared at a jurisdictional level.

Example Documentation or Evidence: Acceptable evidence includes standard operating procedures, written agreements, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 6

Function 3: *Exchange information to determine a common operating picture*

a. Planning Implementation

Intent: Establishing a common operating picture is a vital tool to improve situational awareness between and among relevant partners. Some examples of platforms that may be used to establish this common operating picture include Health Alert Network, other notification service/system, e-mail distribution lists, etc.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, training materials, training rosters, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 6

a. Operational Implementation

Intent: Jurisdictions should demonstrate operational information sharing capacity by testing the establishment of a common operating picture. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes access to or screenshots of data-sharing platforms being used, AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); PHIN Standards (http://www.cdc.gov/phin/)

Capability 8: Medical Countermeasure Dispensing

Function 1: *Identify and initiate medical countermeasure dispensing*

a. Planning Implementation

Intent: Dispensing strategies are necessary to account for the population in need within a jurisdiction. While open (public) PODs may serve the largest population, alternate dispensing modalities, such as closed PODs and strategies to reach those with access and functional needs, should be part of the jurisdictional plan to provide a tiered approach to serve all the population. Such plans must clearly identify processes for providing prophylaxis via the following mechanisms, at a minimum:

- Open (public) PODs: Open PODs have been the primary focus of dispensing operations since the early days of planning for large-scale MCM dispensing campaigns. They are referred to as "open" because there are no restrictions on who can go to them; they are open to everyone.
- Closed PODs: Closed PODs are dispensing sites that are closed to the general public and open only to a specific group (e.g., staff of a participating business or healthcare personnel in a specific hospital).
- Alternate dispensing for populations with access and functional needs: Individuals in need of alternate dispensing mechanisms may include those who have disabilities; live in institutionalized settings; are seniors; are children; are from diverse cultures; have limited English proficiency or are not English speaking; or are transportation disadvantaged.

Example Documentation or Evidence: Evidence that dispensing strategies based on population needs are documented in jurisdictional plans. For example, plans should include:

- Descriptions of open (public) POD strategies
- Descriptions of alternate modalities
- Procedures to initiate, execute, maintain and demobilize alternate modalities
- Identification of partners involved in alternate modalities
- Identification of staffing and resource needs for alternate modalities

Reference(s): Presidential Policy Directive (PPD) 8: National Preparedness (http://www.dhs.gov/xlibrary/assets/presidential-policy-directive-8-national-preparedness.pdf); Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 1; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 10.4

a. Operational Implementation

Intent: Dispensing strategies for designated special groups will differ from strategies for the general population. Jurisdictions should test plans for all tiers to demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles. While locals often have direct responsibility for this operational element, states may have a role by dispensing directly to state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review. These scoring criteria are meant to account for all dispensing strategies. Therefore, the jurisdiction's implementation level will be reviewed based on the least advanced exercise category. For example, if a jurisdiction conducts full-scale exercises for open (public) POD and closed POD strategies and a tabletop for alternate dispensing strategies for populations with access and functional needs, then that jurisdiction would be considered at an intermediate level.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Some dispensing scenarios call for proficiency in initiating a dispensing campaign and later transitioning to a sustained response. For example, an aerosolized anthrax scenario will call for an initial 10-day regimen of prophylaxis, followed by a 50-day regimen of prophylaxis. Similarly, a pandemic influenza response may necessitate a transition from an initial vaccine push to a sustained vaccine administration campaign. To be successful, jurisdictions must be proficient in both initiating and sustaining a dispensing campaign. An advanced level of planning implementation indicates that the jurisdiction can sustain prolonged dispensing operations for 100% of the jurisdiction's population.

Example Documentation or Evidence: Acceptable evidence includes documentation of these procedures in jurisdictional plans, including process descriptions, algorithms, flow charts, checklists, and field-operating guides.

Reference(s): CDC POD Standards (April 2008); DSNS Anthrax Response Plan, June 2014

b. Operational Implementation

Intent: Actions necessary for conducting the initial dispensing campaign and transitioning to a prolonged response will have many operational components. Jurisdictions should test these plans to demonstrate operational readiness. Exercise types are defined according to HSEEP principles. While locals often have direct responsibility for this operational element, states may have a role in initiating and sustaining dispensing operations for state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

c. Planning Implementation

Intent: It is important that jurisdictions identify and include their healthcare partners, as defined by the jurisdiction, in MCM-related operational and planning activities.

Example Documentation or Evidence: Documentation of these procedures could include, standard operating procedures, contracts, emergency operations plans (EOP) and annexes that describe roles and responsibilities of healthcare partners, letters of agreement, memoranda of agreement (MOA), memoranda of understanding (MOU), or any other official document which describes the role of these organizations.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Section 11; SNS State TAR User Guide Version 1.0 (2012), Section 12.

c. Operational Implementation

Intent: Jurisdictions should coordinate with healthcare partners to ensure that these partners have the operational capacity to respond appropriately to an MCM event. Specifically, jurisdictions should coordinate with healthcare partners, as applicable, to exercise closed POD plans. Similarly, jurisdictions should coordinate with healthcare partners to test MCM asset request procedures, as appropriate.

Example Documentation or Evidence: Evidence may include AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): SNS Local TAR User Guide (2010), Section 11; SNS State TAR User Guide Version 1.0 (2012), Section 12; Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 2: *Receive medical countermeasures at POD*

a. Planning Implementation

Intent: Having a pre-established plan or site survey to initiate operations at a POD site shortens the time it takes to begin dispensing to the population in need. Set-up procedures at a dispensing site are conducted more efficiently when administrative details, including necessary resources, contact lists, and written agreements, have been considered prior to the opening of the site. This element applies to open (public) PODs.

Example Documentation or Evidence: Documentation of these procedures could include staff contact lists, standard operating procedures, contracts, EOP with annexes describing roles and responsibilities of jurisdictional agencies. Additional examples include letters of agreement, MOAs, MOUs, mutual aid agreements, or any other official document which describes the role of public health and carries with it an expectation that public health will undertake certain MCM-related activities.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014); SNS Local TAR User Guide (2010), Element 10.7 and 10.8

b. Operational Implementation

Intent: Jurisdictions should test site set-up plans to demonstrate operational readiness. Jurisdictions should conduct site activations that address specific facility characteristics of any potential dispensing site that would be used in an MCM incident. Facility set-up requirements are in the facility set-up drill template included in the MCM Reference Guide. Exercise types are defined according to HSEEP principles, and testing can include a drill, a functional exercise, a full-scale exercise, or an incident. This element applies to open (public) PODs. While locals often have direct responsibility for this operational element, states may have a role in dispensing site set-up for certain facilities, such as universities, in addition to applicable local monitoring and training responsibilities.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Elements identified in the facility set-up drill template should be documented for each facility set-up.

NOTE: Local jurisdictions are only required to submit one facility set-up drill within DCARS, if they choose to use a facility set-up as one of the three required drills. Acceptable evidence may also include AARs, CAPs, IPs, reference exercises that occurred no more than five years from the date of the review or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); PHEP Medical Countermeasure Reference Guide – Facility Set-Up Drill

Function 3: *Activate dispensing modalities*

a. Planning Implementation

Intent: Successful dispensing campaigns require sufficient personnel resources to staff general dispensing sites. A jurisdiction should determine and document in its plans the necessary number of staff to account for the population to be served. For this element, the denominator will be the number of personnel required to staff all open (public) PODs (planning estimates) and the numerator will be the number of personnel actually identified. An advanced level of implementation indicates a jurisdiction has identified and pre-

assigned personnel according to operational position and geographical assignment. For all identified staff, jurisdictions should maintain and make accessible contact information that is updated quarterly. This element applies to open (public) PODs.

Example Documentation or Evidence: Acceptable evidence may include staff contact lists, human resources or volunteer database reports, other tracking systems, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

a. Operational Implementation

Intent: Core management staff, which will oversee all critical positions (as defined by the jurisdiction) at the dispensing site, should be readily available to activate for a dispensing mission. To effectively assess and improve operational performance and provide a realistic understanding of response capability, jurisdictions should collect data to measure staff performance for each of the required operations and response activities (notification, acknowledgement, and availability to assemble). This element applies to open (public) PODs. Local jurisdictions can use exercises conducted in the context of the staff notification drill as long as they choose to include the POD staff. States may have a role in conducting call down drills for core staff included in dispensing operations for state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

Example Documentation or Evidence: Acceptable documentation may consist of tables, spreadsheets, databases, or automated systems (e.g. Health Alert Network) and includes an acknowledgement report for all personnel.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Medical Countermeasure Reference Guide – 'Staff Notification' Drill; SNS Local TAR User Guide (2010), Elements 2.3 and 10.9

Function 4: *Dispense medical countermeasures to identified population*

a. Planning Implementation

Intent: For a dispensing campaign to operate smoothly and effectively, there are many operational issues that must be considered during the planning phase. In a large-scale mass prophylaxis/dispensing incident, there may be a need to quickly modify the clinic flow at a site to increase the throughput and improve screening forms to accommodate a changing situation, based on specific trigger points. In addition, jurisdictions will have unique operational issues for populations with access and functional needs, such as

those who have disabilities; live in institutionalized settings; are seniors; are children; are from diverse cultures; have limited English proficiency or are not English speaking; or are transportation disadvantaged. This element applies to open (public) PODs.

Example Documentation or Evidence: Acceptable documentation may consist of facility flow diagrams, sample screening forms, dispensing algorithms, decision matrices, patient information forms, standard operating procedures that identify care of those with access and functional needs, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 3 Performance Measure Specifications and Implementation Guidance (2014): Capability 1; SNS Local TAR User Guide (2010), Elements 10.2, 10.3 and 10.4

a. Operational Implementation

Intent: Jurisdictions must test planning assumptions and demonstrate operational readiness for dispensing site operations. Therefore, all planning elements associated with Function 4(a) should be tested to validate assumptions. This will involve testing the jurisdiction's required throughput to dispense to the necessary population for a designated dispensing site. The ability to serve the necessary number persons per hour at the dispensing site is crucial to the success of the dispensing campaign, both at the designated dispensing site and for the jurisdiction. Necessary throughput is defined as the hourly throughput to prophylax 75% of the estimated population for that specific POD within the required 48-hour timeframe (as per a CRI scenario). This element applies to open (public) PODs. While locals often have direct responsibility for this operational element, states may have a role in dispensing operations for state employees, military installations, federal employees, or tribal nations, in addition to applicable local monitoring and training responsibilities.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review. POD throughput data can be collected in either of two ways: 1) by recording time to process persons at each POD step or 2) by collecting entry and exit times ("front door to back door") for each person. Modeling programs, such as RealOpt, can also serve as a baseline for throughput estimates for planning purposes. However, these estimates must be validated through a functional exercise, a full-scale exercise, or an incident. For throughput verification, documentation must provide evidence that planning estimates (i.e., necessary throughput) have been achieved (i.e., actual throughput). **Validation of throughput at a designated dispensing site can serve as validation for other dispensing sites as long as the other sites follow a similar operational design (drive through, walk through, etc.) and will require similar throughputs to serve the required population.**

To calculate the percent of sites tested for this element, the denominator should include the total number of PODs within the jurisdiction, and the numerator should include all tested PODs. Multiple PODs may be included in the numerator even if they are not directly tested if a POD of the same operational design and necessary throughput has been tested. For example, a jurisdiction has a total of 15 PODs; 10 are walk-through PODs that have similar necessary throughputs and the other five have different operational designs or require different necessary throughputs. If the jurisdiction tested one of the 10 similar walk-through PODs and four of the remaining five PODs, percent of sites tested would be calculated using a denominator of 15 and a numerator of 14, leading to a percent of sites tested of 93% (14/15).

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Medical Countermeasure Reference Guide – Dispensing Throughput Drill

b. Planning Implementation

Intent: Jurisdictions should understand, prior to an MCM incident, when, why, and by whom changes to the dispensing model can be made. Jurisdictions must pre-determine these protocols, including identifying individuals authorized to alter the clinical model and the steps necessary to transition between models. This element applies to open (public) PODs. For this element, the following terms are defined as:

- Full medical (clinical) POD: In the medical model, each person receives a medical assessment and MCMs from a licensed medical professional. Under this model, medical personnel would dedicate more time to providing a personalized medical evaluation and education on the agent and MCMs to each client at the dispensing site.
- Non-medical (rapid dispensing) POD: The non-medical model refers to a modification of the medical model that streamlines dispensing operations to achieve rapid dispensing. The goal of rapid dispensing is to increase the number of people who can go through a POD, also known as increasing throughput. In light of the anticipated large number of individuals requiring MCMs during an emergency and the timeframe in which the jurisdiction must accomplish dispensing, the non-medical model takes into account limited medical staffing and decreased time to provide MCMs. In this model, individuals might receive a less comprehensive screening form; steps in the dispensing process might be combined or eliminated; or trained nonmedical personnel may dispense MCMs under limited supervision from licensed medical professionals.

Example Documentation or Evidence: Acceptable documentation may consist of standard operating procedures that identify the above issues, in addition to one or more of the following: decision matrix, authorization letter, checklist, algorithm, flow plan, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 10.4

Function 5: *Report adverse events*

a. Planning Implementation

Intent: Each person who receives medication must also be provided with information about what to do and where to go if they experience an adverse reaction to the medication. Some POD designs involve a group briefing given to individuals by dispensing site staff, and so staff must be familiar with reporting protocols as well. This information should also be incorporated into job aids, handouts and signage. Dispensing plans should consider the language and reading skills of the population. Materials should be designed to accommodate those needs (e.g., multiple languages, use of pictures). This element applies to open (public) PODs.

Example Documentation or Evidence: Acceptable evidence includes job aids (including job action sheets), information sheets, and standard operating procedures that account for the above.

Reference(s): CDC POD Standards (April 2008), Page 16

Capability 9: Medical Material Management and Distribution

Function 1: *Direct and activate medical material management and distribution*

a. Planning Implementation

Intent: The receiving sites are the hubs from which the jurisdiction coordinates the distribution of critical resources. The jurisdiction should have adequate receiving sites to meet the supply and demand for its respective resources and population. *At a minimum, awardees should identify a primary and a back-up RSS site.* These sites should be strategically located to move assets quickly to those in need during an emergency. Additionally, to ensure operational effectiveness, each awardee should complete a current RSS site survey (formerly RSS checklist) for each facility and submit to CDC via the MCM SharePoint site. Per CDC guidance, any facility an awardee designates for potential receipt of federal assets must upload the RSS site survey to CDC's MCM SharePoint site. Jurisdictions that identify regional distribution sites (RDS) or local distribution sites (LDS) that may only receive assets from the state should submit similar documentation according to state policies and protocols. All site survey documentation should be updated at least every three years.

Example Documentation or Evidence: Acceptable evidence may include CDC RSS site survey form (or similar documentation for RDS/LDS), standard operating procedures, written agreements, GIS overlays and/or maps.

Reference(s): CDC POD Standards (April 2008), 4.3; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 7.1

a. Operational Implementation

Intent: Jurisdictions should test their receiving site plans according to CDC's distribution planning standards and jurisdictional planning assumptions and demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Medical Countermeasure Reference Guide

b. Planning Implementation

Intent: It is vital that jurisdictions identify and establish contractual agreements with the agencies or organizations responsible for providing distribution assets (e.g. vehicles, drivers, mechanics, etc.). Alternate sources of such assets are essential in the event the primary distribution source is either unable to fulfill its requirements or needs additional assistance due to the severity of the incident. Finally, jurisdictions should plan for the appropriate number and type of resources to best support their distribution strategies.

Example Documentation or Evidence: Acceptable evidence may include written agreements, standard operating procedures, transportation assets lists (including number of vehicles needed, types of vehicles needed, number of drivers needed, and type and number of support personnel needed), etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Elements 10.3, 10.4 and 10.5

b. Operational Implementation

Intent: Jurisdictions should test their distribution strategies according to CDC's distribution planning standards and jurisdictional planning assumptions and demonstrate operational readiness. Exercise types are defined in accordance with HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Medical Countermeasure Reference Guide

c. Planning Implementation

Intent: To prepare for a successful warehouse operation, jurisdictions must identify personnel for management positions, including back-up personnel, and maintain their contact information for receiving sites. The intent of this element is to determine whether a jurisdiction has identified and trained personnel to ensure coverage for all receiving site (RSS/RDS/LDS) functions. An advanced level of implementation indicates a jurisdiction has identified and pre-assigned trained personnel according to operational position and geographical assignment at a relevant receiving location.

Example Documentation or Evidence: Acceptable evidence may include contact lists, job aids, standard operating procedures, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 7.4

c. Operational Implementation

Intent: All necessary personnel that would be required to fully staff a receiving site fully should be readily available to activate to receive critical resources. To effectively assess and improve operational performance and provide a realistic understanding of response capability, jurisdictions should collect data that allows for measurement of staff performance for each of the required operational and response activities (notification, acknowledgement, and staff assembly). Local jurisdictions can use exercises conducted in the context of the staff notification drill, as long as they choose to include the RDS/LDS staff, if applicable.

Example Documentation or Evidence: Acceptable documentation may consist of tables, spreadsheets, databases, or automated systems (e.g. health alert network) and includes an acknowledgement report for all personnel.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 7.12; Medical Countermeasure Reference Guide – 'Staff Notification' Drill

Function 2: *Acquire medical material*

a. Planning Implementation

Intent: To maximize the amount of available time to provide prophylaxis and / or treatment to populations at risk, a jurisdiction should establish processes to inform officials on decisions to request assistance from jurisdictional, private, regional, and/or federal partners during the early stages of a public health emergency.

Example Documentation or Evidence: Acceptable evidence may include algorithms, decision matrices with trigger points, standard operating procedures, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 3.2

a. Operational Implementation

Intent: Jurisdictions should test their requesting procedures and demonstrate operational readiness. The intent of this element is for the jurisdiction to go through the decision-making process and request critical resources through the appropriate channels, not necessarily requesting resources from each individual sector. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Lot numbers and expiration dates will be used to identify products that may be recalled. Therefore, jurisdictions should have plans to track the distribution of MCM by lot number. The Drug Enforcement Administration (DEA) regulates the storage and transfer of controlled substances according to Title 21 of the U.S. Code of Federal Regulations. Plans, policies, and procedures for the chain of custody and cold chain management must comply with all regulatory guidance. A good plan should identify those authorized to sign for controlled substances by position.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, relevant forms, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Title 21 of the U.S. Code of Federal Regulations; SNS State TAR User Guide Version 1.0 (2012), Elements 8.3 and 8.5

b. Operational Implementation

Intent: Jurisdictions should test their plans to maintain integrity of medical material and demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx); Title 21 of the U.S. Code of Federal Regulations; Medical Countermeasure Reference Guide

Function 3: *Maintain updated inventory management and reporting system*

a. Planning Implementation

Intent: An inventory management system (IMS) expedites the management, allocation, control and reordering of critical resources for an effective response. For this element, an IMS should be accessible (i.e., "ready to use") and is defined as a computer-based database for tracking inventory levels and organizing warehouse, orders, sales, and deliveries. A strong IMS should have the capability to perform the following warehouse operations: receive, put away (store), pick (including stage), and ship. Jurisdictions should also identify a back-up system. State facilities are required to report inventory counts during a public health incident. These data elements are important for managing Food and Drug Administration (FDA) recalls by targeting facilities and locations that store or dispense medical countermeasures outlined by the recall.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, relevant IMS reports, screenshots, system demonstrations, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 8.1

a. Operational Implementation

Intent: Jurisdictions should test their inventory management systems and demonstrate operational readiness to receive, store, pick, and ship assets. Jurisdictions should test the primary and alternate systems and train staff on each system.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review, training logs, etc.

Reference(s): Medical Countermeasure Reference Guide; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

b. Planning Implementation

Intent: To expedite a response, it is imperative that public health authorities have knowledge of real-time jurisdictional resource needs. Efficiently tracking and reporting actual inventory levels maintains accountability and enables a timely response. For this element, entity is defined as relevant sites for dispensing or coordinating dispensing of medical countermeasures in the jurisdiction. Jurisdictions should train staff on collection procedures.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, training logs, IMS report forms, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

b. Operational Implementation

Intent: Jurisdictions should test their ability to effectively track and report on inventory levels to demonstrate operational readiness. Additionally, PHEP *awardees* are now required to report inventory levels to CDC's Division of Strategic National Stockpile (DSNS)

using IMATS or an existing inventory management system configured with CDC's "Inventory Data Exchange Specification Standards." Local jurisdictions should be able to report inventory levels to the states, as appropriate.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, IPs, CAPs, drill documentation, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review, CDC/DSNS validation (for Awardees), etc.

Reference(s): CDC, Inventory Data Exchange Specification Standards; Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

Function 4: *Establish and maintain security*

a. Planning Implementation

Intent: The distribution sites (RSS/RDS/LDS) are essential components of a mass prophylaxis campaign. Any incident that compromises security, maintenance, receipt, and distribution activities may result in material not reaching the affected population. Jurisdictions should include the following elements in distribution site security plans.

- Interior physical security of location: security sweep prior to facility use or occupancy by staff or product, establishment of law enforcement officer posts, access control to locations within the facility, and crowd control inside the facility
- Exterior physical security of location: specialized unit needs (canine, explosive ordnance disposal, tactical, traffic, etc.), additional physical barriers (necessity or identification of source), additional lighting (necessity and/or identification of source), staging area for personnel and vehicles, vehicular traffic control (entrances and exits), crowd control outside the facility, and access control to facility
- Command and management: established command center for law enforcement, determined radio channels, ensure communication and coordination between law enforcement organizations, established shifts, and established sufficient number of law enforcement officer assignments
- Evacuation plans

- Security breach plans

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, etc. for each distribution site.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 6.4

a. Operational Implementation

Intent: Jurisdictions should test the security plans for each distribution site to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review for each distribution site exercised.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: The dispensing sites are also essential components of a mass prophylaxis campaign. Any incident that compromises security, maintenance, receipt, and distribution activities may result in material not reaching the affected population. The jurisdiction should use the expertise of law enforcement and other security professionals to ensure the safety and security of the facility, entrances and exits for vehicular and pedestrian traffic, and emergency response plans for each dispensing site. This allows local departments to conduct life-saving operations quickly and effectively. Well-developed dispensing site security plans should include the following elements.

- Interior physical security of location: security sweep prior to facility use or occupancy by staff or product, establishment of law enforcement officer posts, access control to locations within the facility, and crowd control inside the facility
- Exterior physical security of location: specialized unit needs (canine, explosive ordnance disposal, tactical, traffic, etc.), additional physical barriers (necessity and/or identification of source), additional lighting (necessity or identification of source), staging area for personnel and vehicles, vehicular traffic control (entrances and exits), crowd control outside the facility, and access control to facility

- Command and management: established command center for law enforcement, determined radio channels, ensure communication and coordination between law enforcement organizations, established shifts, and established sufficient number of law enforcement officer assignments
- Evacuation plans
- Security breach plans.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, etc. for each dispensing site.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Elements 6.3 and 6.5

b. Operational Implementation

Intent: Jurisdictions should test the security plans for each dispensing site to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review for each dispensing site that is exercised.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

c. Planning Implementation

Intent: Jurisdictions must develop plans detailing the security of federal MCM in rapid transit and delivery to the affected population. Crossing jurisdictional lines and governmental sovereignty, if not addressed and coordinated early, may result in delays or restrictions in the delivery of medical material. For this element, distribution phases may include: 1) MCM arriving at RSS, 2) MCM transported from RSS to RDS/LDS/POD, and 3) MCM transported from RDS/LDS to POD (where applicable).

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, contracts, EOPs and annexes, letters of agreement, MOAs and MOUs, or any other official document that describes the role of these partners, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 6.2

c. Operational Implementation

Intent: Jurisdictions should test the security plans for each phase of transit (referenced in Function 4 (c), Planning) to demonstrate operational readiness. Percentages should be calculated based on phases of transit from the planning element that are applicable to the jurisdiction (i.e., if a jurisdiction is only responsible for three of the phases, the denominator for this calculation should be three). Exercise types are defined according to HSEEP principles.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review for each transportation security plan that is exercised.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 5: *Distribute medical material*

a. Planning Implementation

Intent: Effective, timely, and uninterrupted deliveries are essential to the success of a mass prophylaxis campaign. Plans may include maps showing potential routing strategies, traffic flow patterns, results from modeling programs, strategies for how to handle vehicle repairs, maintenance, fueling and refueling, or other emergent issues with vehicles, and delivery locations identified via maps or GIS software.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, route optimization reports, allocation tables, GIS overlays, physical maps, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS State TAR User Guide Version 1.0 (2012), Element 10.2

a. Operational Implementation

Intent: Jurisdictions should test their ability to transport critical resources from the receiving sites to the dispensing sites. In PHEP jurisdictions, distribution of critical resources from RSS to all dispensing sites should occur within 12 hours of receipt of material. At the regional or local level, if an RDS or LDS is used, distribution of critical resources should still reach all dispensing sites within the same 12 hours. Therefore, planning assumptions for distribution timelines should account for the time involved to receive material from the RSS. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): PHEP Medical Countermeasure Reference Guide

Function 6: *Recover medical material and demobilize distribution operations*

a. Planning Implementation

Intent: To successfully demobilize distribution operations, jurisdictions need to plan for the recovery of critical resources after an incident. This will enable the jurisdiction to efficiently restore systems, supplies, and staffing as required to support distribution operations. Waste management is of special note in the process of recovering resources, as resources that require special handling and disposition (e.g., biological waste and contaminated supplies, debris, and equipment) are managed according to established regulations and policies. Plans should also consider identifying any sensitive item that is deemed “recoverable” by the federal government.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, etc.

Reference(s): FEMA, National Incident Management System (NIMS Resource Management)

a. Operational Implementation

Intent: Jurisdictions should test their recovery and waste disposal plans and demonstrate operational readiness in these areas. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Capability 14: Responder Safety and Health

Function 1: *Identify responder safety and health risks*

a. Planning Implementation

Intent: An MCM incident and the subsequent dispensing campaign may have various adverse effects on responders, including medical or mental health issues related to the stress of the incident. Jurisdictions should maintain plans to mitigate these risks, as well as offer expert guidance on securing their health and safety.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, job aids, SME guidance, responder resource inventory, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

a. Operational Implementation

Intent: Jurisdictions should test their plans for public health responder protection by incorporating these principles into an exercise or incident that demonstrates operational readiness. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

b. Planning Implementation

Intent: Certain groups of personnel are critical to the execution of a jurisdiction's distribution and dispensing plans. Therefore, it is essential for jurisdictions to determine how best to provide for these groups and their families while allowing them to continue supporting the operation. For this element, the following terms are defined as:

- First responders: individuals who, in the early stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in Section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101). Also included are emergency management, public health, clinical care, public works, and other skilled support personnel (such as equipment operators) who provide immediate support services during prevention, response, and recovery operations.
- Critical infrastructure staff: individuals involved in managing public works, emergency services, transportation, information technology, government, or any other system or asset that would have a debilitating impact on the community if not maintained.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, staff contact lists, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; Presidential Policy Directive (PPD) 8: National Preparedness (http://www.dhs.gov/xlibrary/assets/presidential-policy-directive-8-national-preparedness.pdf); SNS Local TAR User Guide (2010), Element 10.5

b. Operational Implementation

Intent: Jurisdictions should test their plans for the priority prophylaxis of staff and volunteer responders, including critical infrastructure personnel and first responders, to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 2: *Identify safety and personal protective needs*

a. Planning Implementation

Intent: An incident requiring the distribution and dispensing of MCM will have the potential to expose staff and volunteer responders to hazardous conditions. Personal protective equipment (PPE) will be required to ensure that responders can safely operate in the affected area. Successful strategies to use PPE will include training, fit-testing, and medical clearance for responders. This applies to any and all responders who may be exposed to hazardous conditions as part of their response roles.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, training logs, medical release forms, written agreements, responder resource inventory, etc. For this element, evidence that the PPE planning criteria are met *for at least one MCM scenario* is sufficient for Budget Period 4. If a jurisdiction is not directly responsible for medical clearance of PPE, evidence may be accepted from other entities (i.e., occupational safety and health).

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

Function 3: *Coordinate with partners to facilitate risk-specific safety and health training*

a. Planning Implementation

Intent: Jurisdictions should plan to provide just-in-time training to their responders on MCM-related health risks, including the use of appropriate PPE, dispensing site security protocols, agent-specific threat information, etc. The needs of the various responder groups may differ, and jurisdictions should consider these differences in their training plans. For this element, the following terms are defined as:

- First responders: individuals who, in the early stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment, including emergency response providers as defined in Section 2 of the Homeland Security Act of 2002 (6 U.S.C. 101). Also included are emergency management, public health, clinical care, public works, and other skilled support personnel (such as equipment operators) who provide immediate support services during prevention, response, and recovery operations.

- Critical infrastructure staff: individuals involved in managing public works, emergency services, transportation, information technology, government, or any other system or asset that would have a debilitating impact on the community if not maintained.

Example Documentation or Evidence: Acceptable evidence may include training logs, training materials, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

Function 4: *Monitor responder safety and health actions*

a. Planning Implementation

Intent: Responder injuries, illnesses, exposures, and fatalities are often preventable. To address immediate operational safety and health concerns, jurisdictions must monitor the health of responders and adhere to health and safety recommendations. This includes the provision of medical and behavioral health services and identification of broader programmatic factors for which corrective actions can be developed and implemented.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements for the provision of services, job aids, SME guidance, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 14

a. Operational Implementation

Intent: Jurisdictions should test their plans for monitoring responder safety and health according to these planning elements to demonstrate operational readiness. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Capability 15: Volunteer Management

Function 1: *Coordinate volunteers*

a. Planning Implementation

Intent: Identifying, screening, and training volunteers helps ensure adequate staffing levels for a dispensing campaign will be available in a timely manner. The identification of volunteers from a single point source, such as a volunteer registry tracking system, is optimal for the management and coordination of the volunteer pool that would be used during an MCM incident. Since volunteers may be used for various response activities, jurisdictions should ensure an adequate number of volunteers are dedicated to dispensing operations, according to jurisdictional staffing needs.

Example Documentation or Evidence: Acceptable evidence may include ESAR-VHP documentation, volunteer registry reports, standard operating procedures, training logs, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 15; SNS State TAR User Guide Version 1.0 (2012), 11.2

a. Operational Implementation

Intent: Jurisdictions should test their plans for volunteer coordination to support a dispensing campaign and demonstrate operational readiness in this area. Exercise types are defined according to HSEEP principles.

NOTE: A jurisdiction can only receive an advanced level of implementation if all applicable criteria from the planning element are tested at the level of exercise/incident indicated for this element. If the jurisdiction tests (via exercise or incident) at least one criterion, but less than the total number of criteria, the jurisdiction will receive an intermediate/established level of implementation depending on the type of exercise/incident conducted. If the jurisdiction does not test any of the criteria in the planning element, the jurisdiction will receive an early level of implementation.

Example Documentation or Evidence: Acceptable evidence includes AARs, CAPs, IPs, or other HSEEP-defined exercise planning documents that reference exercises that occurred no more than five years from the date of the review.

Reference(s): Homeland Security Exercise and Evaluation Program (https://hseep.dhs.gov/pages/1001_About.aspx)

Function 2: *Notify volunteers*

a. Planning Implementation

Intent: To ensure the timely initiation of dispensing activities, jurisdictions should establish procedures that will be used during a dispensing campaign to notify volunteers and partner agencies of the incident and to confirm the validity of volunteer credentials.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, written agreements, contact lists, etc.

Reference(s): *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011), Capability 15; SNS State TAR User Guide Version 1.0 (2012), Element 2.6

a. Operational Implementation

Intent: It is necessary to test volunteer notification systems and credential verification processes to ensure the timely initiation of dispensing activities.

Example Documentation or Evidence: Acceptable documentation may consist of tables, spreadsheets, databases, or automated systems (e.g. Health Alert Network) and includes an acknowledgement report for all personnel.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11

Function 3: *Organize, assemble, and dispatch volunteers*

a. Planning Implementation

Intent: To ensure an efficient an effective response during an emergency, it is essential to protect the personnel responsible for the various functions of a dispensing campaign. At a minimum, jurisdictions should coordinate necessary support services for volunteer staff. Further, volunteers should understand how they integrate into the response, what their roles are and what support services are available to them.

Example Documentation or Evidence: Acceptable evidence may include job aids, training materials, standard operating procedures, written agreements, briefing materials, guidance materials, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; SNS Local TAR User Guide (2010), Element 10.13

b. Planning Implementation

Intent: Establishing access-control measures lessens the probability that unauthorized individuals will gain access to sensitive and/or confidential response areas. Additionally, emergency management or other security resources may need to coordinate the access and management of volunteers, including volunteers who are not associated with any public health or emergency management response system prior to the incident (i.e., spontaneous volunteers).

Example Documentation or Evidence: Acceptable evidence may include job aids, standard operating procedures, written agreements, etc.

Reference(s): Receiving, Distributing and Dispensing SNS Assets: A Guide to Preparedness, Version 11; FEMA, "Managing Spontaneous Volunteers in Times of Disaster" (http://www.fema.gov/pdf/donations/ManagingSpontaneousVolunteers.pdf); SNS Local TAR User Guide (2010), Element 6.4

Function 4: *Demobilize volunteers*

a. Planning Implementation

Intent: To efficiently and effectively coordinate the demobilization of volunteers, jurisdictions should have processes and systems in place to allow for the tracking, out-processing, and follow-up or provision of contingency services following the incident. For this element, tracking volunteers refers to the process, plans, or procedures to capture volunteer activities, roles, locations, etc. Out-processing volunteers refers to the return of equipment, operational debriefing, and any transfer of command or other responsibilities.

Example Documentation or Evidence: Acceptable evidence may include standard operating procedures, system reports, written agreements, etc.

Reference(s): PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013), Capability 15

Key Terms

Name	Description
All-hazards	Describing an incident, natural or manmade, that warrants action to protect life, property, environment, and public health or safety, and to minimize disruptions of government, social, or economic activities.
Common Operating Picture	A continuously updated overview of an incident compiled throughout an incident's life cycle from data shared between integrated systems for communication, information management, and intelligence and information sharing. The common operating picture allows incident managers at all levels to make effective, consistent, and timely decisions. The common operating picture also helps ensure consistency at all levels of incident management across jurisdictions, as well as between various governmental jurisdictions and private-sector and nongovernmental entities that are engaged.
Devolution	The capability to transfer statutory authority and responsibility for essential functions from an organization's primary operating staff and facilities to other organization employees and facilities, and to sustain that operational capability for an extended period.
Element	An essential part or aspect of each function within the public health preparedness capability.
Event	A planned, non-emergency activity (e.g., full-scale exercise, sporting event, concert, parade, etc.).
Function	Describes the critical elements that need to occur to achieve the capability.
Hazard Vulnerability Analyses (HVA)	A process to identify hazards and associated risks to persons, property, and structures and to improve protection from natural and human-caused hazards.
Healthcare Partners	A network of healthcare organizations, government agencies and providers working together to strengthen emergency preparedness, response and recovery.
Incident	An occurrence, natural or manmade, that requires a response to protect life, including medical emergencies, and other occurrences requiring an emergency response.
Inventory Management System (IMS)	A database or software application developed to manage information regarding medical and non-medical countermeasures.
Jurisdictional Risk Assessment (JRA)	A process of assessing the potential loss or disruption of essential services such as clean water, sanitation, or the interruption of healthcare services, public health agency infrastructure within a specified community.
Jurisdictions	a) Awardees or local planning jurisdictions (e.g., directly funded cities, states, islands, and territories). b) A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority.).
MCM Dispensing	The ability to provide medical countermeasures (including vaccines, antiviral drugs, antibiotics, antitoxin, etc.) in support of treatment or prophylaxis (oral or vaccination) to the identified population in accordance with public health guidelines and/or recommendations.
MCM Distribution	The ability to acquire, maintain (e.g., cold chain storage or other storage protocol), transport, distribute, and track medical material (e.g., pharmaceuticals, gloves, masks, and ventilators) during an incident and to recover and account for unused medical material, as necessary, after an incident.
MCM Incident	A public health emergency or event that requires rapid deployment of medical countermeasures to protect life.

Name	Description
Medical Model (clinical) POD	A type of dispensing model chosen by the jurisdiction during a public health emergency used to operate a POD. In the medical model, each person receives a medical assessment and MCMs from a licensed medical professional. Jurisdictions typically would use the medical model in a dispensing operation that afforded ideal circumstances, such as adequate time and medical staff. Under this model, medical personnel would dedicate more time to providing a personalized medical evaluation and education on the agent and MCMs to each client at the dispensing site. The medical model makes several assumptions for dispensing operations, including: • Each individual is unique, therefore MCMs are provided on a personalized medical evaluation, even if only one or two MCM options are available; • Few or no constraints exist for the type of medical staff who can dispense; • No time constraints exist for conducting medical evaluations or providing MCMs; and • All medical professionals have the necessary training and licensures to provide medical care based on current, best medical practices.
Non-medical Model (rapid dispensing) POD	A type of dispensing model that refers to a modification of the medical model that streamlines dispensing operations in order to achieve rapid dispensing. The goal of rapid dispensing is to increase the number of people who can go through a POD, also known as increasing throughput. In light of the anticipated large number of individuals requiring MCMs during an emergency and the timeframe in which the jurisdiction must accomplish dispensing, the non-medical model takes into account limited medical staffing and decreased time to provide MCMs. In the non-medical model, clients might receive a less comprehensive screening form; steps in the dispensing process might be combined or eliminated; or trained nonmedical personnel may dispense MCMs under limited supervision from licensed medical professionals.
Operational readiness	The capability of a jurisdiction to execute their medical countermeasure distribution and dispensing plans during a public health response.
Orders of Succession	Provisions for the assumption of senior agency offices during an emergency in the event that any of those officials are unavailable to execute their legal duties.
Planning jurisdictions	The number of CRI planning authorities as defined by the state.
Point of Dispensing (POD)	Locations where the members of the public would go to receive life-saving antibiotics or other medical countermeasures during a large-scale public health emergency.
Preparedness	Actions that involve a combination of planning, resources, training, exercising, and organizing to build, sustain, and improve operational capabilities. Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents, and developing jurisdiction-specific plans for delivering capabilities when needed for an incident.
Public Health Emergency	A disease, disorder or significant outbreak of infectious diseases or bioterrorist attacks that presents a risk to the public's health.
Quarterly	Regular intervals every three months, four times a year.
Receiving, Staging, and Storing (RSS) Facility	A site or facility that acts as the hub of the distribution system for the state or jurisdiction to which Strategic National Stockpile (SNS) assets are deployed.
Regional Distribution Site (RDS)/ Local Distribution Site (LDS)	A site or facility selected to receive MCM from the RSS facility for further breakdown and distribution to pre-determined dispensing sites, such as PODs.

Name	Description
Resources	Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained.
Response	Immediate actions to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support recovery.
Third-Party Logistics (3PL)	A company that works with shippers to manage their logistics operations.
Tiered Approach	A systematic and flexible strategy to ensure the entire population is served through POD models that are implemented according to the individual needs of the jurisdiction or community.

References

CDC, *Public Health Preparedness Capabilities: National Standards for State and Local Planning* (March 2011); http://www.cdc.gov/phpr/capabilities/

FEMA, Homeland Security Exercise, and Evaluation Program http://www.fema.gov/media-library-data/20130726-1914-25045-8890/hseep_apr13_.pdf

CDC, PHEP Budget Period 2 Performance Measure Specifications and Implementation Guidance (2013); http://www.cdc.gov/phpr/documents/PHEP_BP2_PM_Specifications_and_Implementation_Guidance_v1_1.pdf

CDC, HPP-PHEP Budget Period 3 Continuation Guidance Supplemental Information Performance Measure Specifications and Implementation Guidance (2014)

CDC, PHEP Budget Period 4 Performance Measure Specifications, and Implementation Guidance (2015)

CDC, Medical Countermeasure Reference Guide

CDC, POD Standards (April 2008): http://www.rand.org/content/dam/rand/pubs/technical_reports/2008/RAND_TR553.pdf

CDC, Receiving, Distributing, and Dispensing SNS Assets: A Guide to Preparedness, Version 11

CDC, "Inventory Data Exchange Specification Standards," (http://www.cdc.gov/phin/library/resources/Tools/IMATS/Inventory_Data_Exchange_Specification.pdf)

DHHS, "Analysis of Risk Communication Strategies and Approaches with At-Risk Populations to Enhance Emergency Preparedness, Response, and Recovery: Final Report (2008)." http://aspe.hhs.gov/daltcp/reports/2008/emergfres.html

FEMA, "Managing Spontaneous Volunteers in Times of Disaster" (http://www.fema.gov/pdf/donations/ManagingSpontaneousVolunteers.pdf)

National Biodefense Science Board "Integration of Mental and Behavioral Health in Federal Disaster Preparedness, Response, and Recovery: Assessment and Recommendations" (2010)

Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), Public Law No. 113-5 (2013), (http://www.phe.gov/Preparedness/legal/pahpa/Pages/pahpra.aspx)

Presidential Policy Directive (PPD) 8: National Preparedness (http://www.dhs.gov/xlibrary/assets/presidential-policy-directive-8-national-preparedness.pdf) (2011)

Title 21 of the U.S. Code of Federal Regulations (http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/ucm135680.htm)

SNS State TAR User Guide Version 1.0 (2012)

SNS Local TAR User Guide (2010)